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**AIDS IN SAN FRANCISCO:**  
**STATUS REPORT FOR FISCAL YEAR 1987-88**  
**AND**  
**PROJECTIONS OF SERVICE NEEDS AND COSTS FOR 1988-93**

APRIL 22, 1988

San Francisco Department of Public Health

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AIDS in San Francisco 1987-88

TABLE OF CONTENTS

Page	Title	Page
	Executive Summary	2
	Introduction	4
	<b><u>AIDS IN SAN FRANCISCO:</u></b>	
I.	<b><u>STATUS REPORT FOR FISCAL YEAR 1987-88</u></b>	7
II.	<b><u>AND</u></b>	27
III.	<b><u>PROJECTIONS OF SERVICE NEEDS AND COSTS FOR 1988-93</u></b>	27
IV.	Conclusions	32
V.	Comments on Method and Major Findings	36
VI.	Appendix A	74
VII.	Appendix B	80
VIII.	<b>APRIL 22, 1988</b>	84
IX.	Appendix C	85
X.	Appendix D	86
XI.	Appendix E	87
XII.	Appendix F	88
XIII.	Appendix G	89
XIV.	Appendix H	90
XV.	Appendix I	91
XVI.	Appendix J	92
XVII.	Appendix K	93
XVIII.	Appendix L	94
XIX.	Appendix M	95
XX.	Appendix N	96
XXI.	Appendix O	97
XXII.	Appendix P	98
XXIII.	Appendix Q	99
XXIV.	Appendix R	100
XXV.	Appendix S	101
XXVI.	Appendix T	102
XXVII.	Appendix U	103
XXVIII.	Appendix V	104
XXIX.	Appendix W	105
XXX.	Appendix X	106
XXXI.	Appendix Y	107
XXXII.	Appendix Z	108

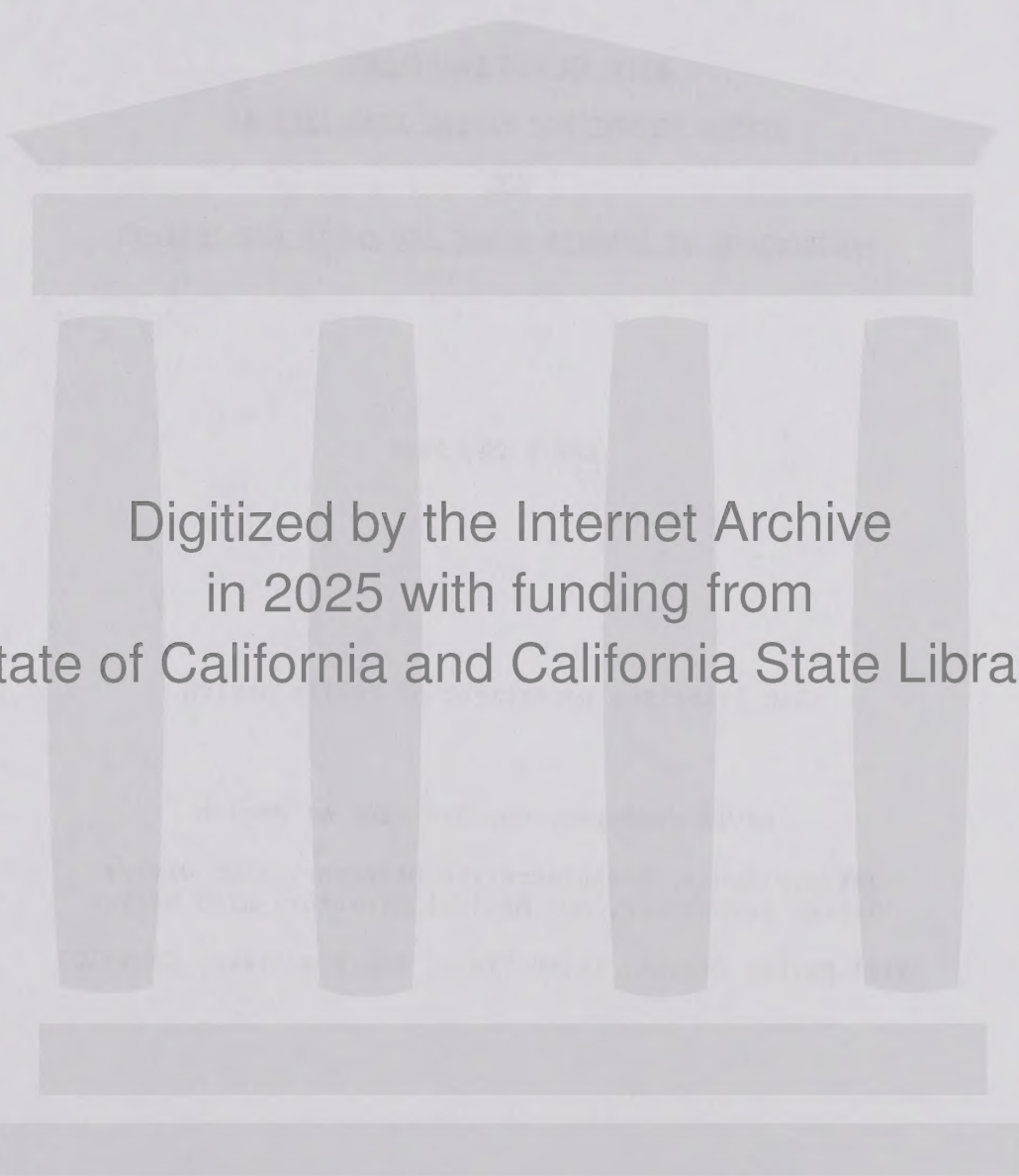
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## TABLE OF CONTENTS

<u>Chapter</u>	<u>Title</u>	<u>Page</u>
	Overview	2
	Introduction	4
	<b>Current Status</b>	
I.	Current Dimensions of the Epidemic in San Francisco	7
II.	Surveillance, Epidemiology, and Related Research	27
III.	Public Education	37
IV.	Concerns of Gay and Bisexual Men	62
V.	Concerns of Racial and Ethnic Minority Groups	68
VI.	Concerns of Women	74
VII.	Concerns of Children and Adolescents	80
VIII.	Provider Education and Staff Support	86
IX.	Primary Care and Specialized Outpatient Care	101
X.	Hospital Inpatient Care	114
XI.	Chronic Care, Housing, and Related Support Services	129
XII.	Mental Health Services	145
XIII.	Substance Abuse Services	158
XIV.	Administrative Support and Coordination	169
XV.	1987-88 Budget Summaries and Cost Estimates	176
	<b>Future Needs</b>	
XVI.	Projected Dimensions of the Epidemic in San Francisco	191
XVII.	Projections of Service Needs for 1988-93	218
	<b>Appendices</b>	
A.	Recapitulation of Policy Statements	263
B.	Organizations and Individuals Invited to Review This Report	281

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OVERVIEW

AIDS IN SAN FRANCISCO: STATUS REPORT FOR FISCAL YEAR 1987-88 AND PROJECTIONS OF SERVICE NEEDS AND COSTS FOR 1988-93 is the amalgamation of two documents. The first reports on activities and services in place in San Francisco during the 1987-88 fiscal year. It establishes the foundation on which the discussion of future needs is based. The second document, represented here as Chapters XVI and XVII, provides an assessment of service needs anticipated each year between 1988-89 and 1992-93.

This consolidated version begins with a description of the purpose and scope of the work done and the process undertaken in developing the report/needs statement. This description is followed by a report of the number of cases of AIDS on record in San Francisco and the number anticipated by June 1988, and subsequently by a discussion of demographic trends and their implications for prevention and health care services. Particular concerns of gay and bisexual men, racial and ethnic minority groups, women, and children and adolescents are addressed in separate chapters. The balance of the status report is organized around nine categories of programs and support services:

- Surveillance, Epidemiology, and Related Research
- Public Education
- Provider Education and Staff Support
- Primary Care and Specialized Outpatient Care
- Hospital Inpatient Care
- Chronic Care, Housing, and Related Support Services
- Mental Health Services
- Substance Abuse Services
- Administrative Support and Coordination.

Each of these chapters includes a discussion of the nature of services/programs covered in the section, an identification of goals, an overview of current service configurations, a summary of factors and constraints which have or will probably have a particular impact on current and/or future services, and a reaffirmation of relevant departmental policies. Since the categories around which the document is organized are not mutually exclusive, there are frequent references to other parts of the document.



This document describes AIDS services currently available in San Francisco regardless of funding source. Programs and activities detailed here represent the San Francisco communities' responses to AIDS as offered through a network of service organizations, including the San Francisco Department of Public Health, community agencies that contract with the Department, and community agencies that are supported entirely by private donations.

The description of services and programs is followed by a summary of funding, by source, currently available to each provider in the continuum. The charts account for all funding (local, State, and Federal) administered directly by the Department of Public Health. When known or when a reasonable estimate can be made, financial support from other sources is also reflected in these charts.

The final two chapters focus on the future. One looks at what seems likely to happen in terms of new cases and their prognosis. The other provides a glimpse of what programs and resources will probably be required to accommodate research, education, and health care needs we can reasonably expect, given what we know today.

In addition to the fact that the San Francisco Department of Public Health has (1) taken the lead in coordinating the community's response to the epidemic and (2) been instrumental in the development of many of the services, programs, and activities that are now available, it also coordinated the efforts of the private sector to provide a wide range of services. Community agencies, including the San Francisco Department of Public Health, have been instrumental in the development of many of the services, programs, and activities that are now available. The San Francisco Department of Public Health has been instrumental in the development of many of the services, programs, and activities that are now available. The San Francisco Department of Public Health has been instrumental in the development of many of the services, programs, and activities that are now available.

The ongoing assessment and planning process in this report addresses the need for the community to continue to address the epidemic. The ongoing assessment and planning process in this report addresses the need for the community to continue to address the epidemic. The ongoing assessment and planning process in this report addresses the need for the community to continue to address the epidemic.

- The epidemic is growing, the impact of education and prevention programs, and the impact of the epidemic on the community.
- What services and programs have been developed to address the epidemic and what services and programs have been developed to address the epidemic.
- How the epidemic has been addressed by the community and how the epidemic has been addressed by the community.
- How planning and assessment can be used to address the epidemic and how planning and assessment can be used to address the epidemic.





## INTRODUCTION

The current epidemics of acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection are the most serious health crises ever faced by the City and County of San Francisco. This document reviews the current situation and provides the general framework necessary for discussions of service and funding requirements anticipated for each year over the next five years.

This report is an extension of an assessment and planning process that began in 1986 and resulted in a document entitled AIDS IN SAN FRANCISCO: STATUS REPORT AND PLAN FOR FISCAL YEAR 1987-88 (REVISED MARCH 1987). This 1988 edition essentially updates and builds on the material presented to the San Francisco Health Commission a year ago.

This document consolidates information about a network of services that have been developed by a variety of providers, some of which depend entirely or in part on government appropriations. It is also one of the few reports of its kind which attempts to assess the extent of the private sector's involvement in supporting services related to the epidemic.

It reflects the fact that the San Francisco Department of Public Health has (1) taken the lead in coordinating the community's overall response to the epidemic and (2) used local, State and Federal funding to support an array of research projects, educational efforts, health care, and support services. It also recognizes that the private sector has played a critical role in this response. Community hospitals accommodate the bulk of the demand for acute inpatient services, and physicians in private practice assume the lion's share of primary care for persons with AIDS and ARC. Community-based organizations, often with some financial assistance from the Department but sometimes entirely on their own, have also played a major role in a wide range of education and out-of-hospital support services.

The ongoing assessment and planning process evident in this report addresses the need for an overview of the current problems associated with managing the epidemic and what has been done to address these problems. More specifically, it reflects the need to continuously assess:

- how the epidemic is growing, the impact of educational and prevention programs, and the demand for AIDS-related services;
- what established services have been expanded or modified and what new services have been developed to accommodate the demand;
- how the financial burden of the epidemic has been or might be distributed among private and public (local, state, national) agencies;
- how planning and management related to the epidemic have been coordinated with governmental agencies and community organizations;



- what progress has been made toward the development of a vaccine and toward the development of effective therapy for both symptomatic and asymptomatic HIV-infected patients; and
- what constraints affect the planning of responses to the epidemic.

The observations contained in this report have been shaped by a variety of intramural and extramural committees, groups, reports, and interactions. They include but are not limited to:

- conversations at meetings of the Executive Committee and Departmental AIDS Committee of the Department of Public Health;
- interviews with current AIDS service providers in San Francisco and review of written materials submitted by many of them;
- discussions about AIDS services and service gaps, involving representatives of current service providers, advocacy groups, task forces, and community-based organizations;
- deliberations of the Director of Health's Medical Advisory Committee on AIDS, AIDS Advisory Committee, and Minority AIDS Task Force on AIDS;
- hearings conducted by the San Francisco Health Commission;
- discussions undertaken by the Mayor's AIDS Task Force;
- reports from the National Academy of Sciences, the Surgeon General of the United States Public Health Service, the Centers for Disease Control, etc.;
- recently enacted State and Federal legislation regarding support for AIDS services; and
- observations about established and anticipated patterns of contracting with State and Federal agencies.

Although this report is addressed to the San Francisco Health Commission, it has been drafted with the assumption that it may also be useful to people outside of San Francisco, who frequently request information about our continuum of services, how programs are funded, etc. It is hoped that readers will appreciate the comprehensiveness of San Francisco's response to AIDS as well as the complexity of the problem being addressed here.

It will be obvious to anyone reviewing this report that enormous amounts of time, energy, and care have gone into the development of the document. And that many, many people have been involved. This remarkable effort seems in concert with the extraordinary commitment many San Franciscans have made to



**AIDS in San Francisco 1987-88**

address this epidemic in a singularly humane and constructive fashion. Their efforts are really what the report is all about. Timely assistance from the staff of the AIDS Office, in particular Kim Lawton, Adam Stern, and Michael Johnson, ensured its completion.

Jeffery W. Amory  
Linda M. Udall

April 13, 1988



## I. CURRENT DIMENSIONS OF THE EPIDEMIC IN SAN FRANCISCO

This chapter will provide a brief review of the numbers commonly used to describe the extent of the epidemics of acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection. The number of AIDS cases is evident from the cases reported to the San Francisco Department of Public Health (DPH). Other indications of the extent of HIV infection are reflected in the data collected on population samples being followed in various epidemiological studies.

### A. REPORTED CASES OF AIDS

By January 31, 1988, 4,371 cumulative cases of AIDS had been reported to the Department of Public Health. This corresponds to an incidence of 644 cases per 100,000 population. Of these 4,371 patients, 2,629 have died, leaving 1,742 persons living with AIDS in San Francisco at the end of January 1988. The number of cases of AIDS diagnosed per month in San Francisco is continuing to rise (Figure 1).

The demographics of AIDS in San Francisco are shown in Tables 1-9. These include:

- 3,692 (84.7%) homosexual and bisexual men, 520 (11.9%) homosexual and bisexual men with histories of intravenous drug use, and 62 (1.4%) heterosexual intravenous drug users;
- 4,325 (98.9%) adult and adolescent men, 33 (0.8%) adult and adolescent women, and 13 (0.3%) children;
- 2,174 (49.7%) 30 to 39 year-olds, 1,146 (26.2%) 40 to 49 year-olds, and 581 (13.3%) 20 to 29 year-olds;
- 3,681 (84.2%) whites, 326 (7.5%) Latinos, 285 (6.5%) Blacks, 75 (1.7%) Asians and Pacific Islanders, and 4 (0.1%) Native Americans.

### B. OTHER HIV-RELATED DISEASES

A diagnosis of AIDS is established when a patient meets certain criteria determined by the Centers for Disease Control as the surveillance definition of AIDS. In very general terms, a diagnosis of clinical AIDS encompasses the more debilitating symptoms associated with HIV infection. Other symptoms or combinations of symptoms are often referred to as AIDS-related conditions or AIDS-related complex (ARC). These are not reportable conditions, but we are able to estimate the number of persons with ARC by extrapolating from data drawn from one of the subsets of the San Francisco City Clinic Cohort Study



described more fully in the following chapter. This cohort indicates that as of January 1988 the ratio of ARC patients with lymphadenopathy syndrome alone is 1.11 per case of AIDS and that the ratio of ARC patients with other symptoms alone or in combination with lymphadenopathy syndrome is 1.61 per case of AIDS. Given these ratios DPH estimates the number of ARC cases in San Francisco at 7,025 on January 31, 1988: 4,839 with lymphadenopathy syndrome alone and 2,186 with other symptoms.

Since the data also suggest that the proportion of ARC to AIDS cases appears to decrease with increasing length of infection, it is expected that the ratio will decline in future years as the average duration of infection lengthens in San Francisco.

### C. SEROPREVALENCE AND SEROCONVERSION DATA

"Seroprevalence" is a term commonly used in discussions of AIDS to indicate the prevalence of HIV antibodies in serum specimens drawn from samples of certain population groups. In situations where the sample is representative of the population being studied, it is believed that seroprevalence in the sample is representative of seroprevalence in the larger group. Seroconversion and seroincidence are related terms which indicate the rate of change of serological status among those previously uninfected (i.e. among those whose blood previously showed no signs of HIV antibody). Data about seroprevalence and seroconversion in two population groups are available in San Francisco.

#### 1. Homosexual and Bisexual Males

Figure 2 shows two estimates of the cumulative seroprevalence for homosexual/bisexual men by year in San Francisco. The curve on the left (stars) shows the cumulative seroprevalence in a cohort of 359 homosexual/bisexual men randomly selected from the City Clinic for sexually transmitted diseases in 1978 to 1980 for studies on the efficacy of Hepatitis B vaccine. The seroprevalence of HIV in this cohort rose from 1% in 1978 to 46.3% by mid-1987.

The curve on the right (boxes) is an estimate of the cumulative HIV seroprevalence in the San Francisco Men's Health Study (SFMHS), a cohort of 799 homosexual/bisexual men randomly sampled in 1984 from households in 19 high risk census tracts in and around the Castro District of San Francisco. Since measurement of seroprevalence in the SFMHS began in 1984 (seroprevalence reached 49.3% in 1986), seroprevalence for the years prior to 1984 had to be estimated. The SFMHS obtained an estimate for 1982 from a subsample of men who reported no high risk behaviors since 1982. The remaining data points (1978 to 1981, and 1983) were estimated by extrapolating the known points for the SFMHS and by simulating the shape of the curve from the actual data available from the Hepatitis B vaccine trial cohort.

Since the SFMHS is a population-based probability sample, the seroincidence curve for that study is more likely to be representative of HIV

seroincidence for homosexual/bisexual men in San Francisco. The SFMHS seroincidence curve was utilized to generate the five-year AIDS forecasts for San Francisco.

Figure 3 shows the proportion of the two cohorts seroconverting to HIV by year. For the Hepatitis B vaccine trial subset of the City Clinic Cohort (stars), the majority of seroconversions occurred during the years 1980, 1981, and 1982, with 15% seroconverting during the peak year, 1982. The seroconversion rate then fell dramatically to 1% in 1983 and declined to less than 1% by 1986. Similarly, seroconversion in the SFMHS (boxes) is estimated to have risen rapidly, peaking at a rate of 20% per year in 1983, with a dramatic decline to a rate of less than 5% by 1986.

The size of the homosexual/bisexual male population in San Francisco was determined using estimates from two separate surveys. The first, a random-digit telephone survey conducted in 1984 (Bye and Associates), estimated 69,122 openly gay or bisexual men in the city.

The second estimate was devised by extrapolating the ratio of AIDS cases among 18,000 homosexual/bisexual men in the 19 census tracts surveyed by the SFMHS (7.3%) to the number of AIDS cases among homosexual/bisexual men in the entire city. This generated an estimate of 42,509 homosexual/bisexual men in San Francisco.

These two estimates suggest that the true number of homosexual/bisexual men in San Francisco is between 42,509 and 69,122. To obtain a mid-point estimate of the population size, we took the average of these two numbers: 55,816.

If we assume that 49.3% of these 55,816 men are infected with HIV, then we estimate that 27,517 homosexual/bisexual men were infected in San Francisco by the end of 1986.

For purposes of forecasting, we assumed that fewer than 1% of homosexual/bisexual men will seroconvert to HIV each year through 1993 (n = 200 seroconversions per year).

## 2. Heterosexual IV Drug Users

Figure 4 shows the estimated cumulative HIV seroprevalence by year for heterosexual IV drug users (IVDUs) in San Francisco. The last three data points (1983-84 to 1986-87) were obtained from the cross-sectional surveys of 98, 281, and 818 heterosexual IVDUs in and out of treatment for IV drug use (methadone maintenance and detoxification). Seroprevalence in these three surveys rose from 6.1% in 1983-84, to 12.7% in 1986-87. The estimates for 1981 to 1983 were extrapolated and adjusted to fit the trend for IVDU-associated AIDS cases in San Francisco. For purposes of forecasting, we assumed that the approximately 3% annual increase in seroprevalence would continue through 1993.



Accurate estimates of the number of heterosexual IVDUs in San Francisco are not readily available. For purposes of forecasting, we assumed that a generally held estimate of 10,000 heterosexual IVDUs was a reasonable estimate of the population. If we assume that 12.7% of these 10,000 heterosexual IVDUs are HIV positive, then we estimate that 1,270 heterosexual IVDUs were infected with HIV in San Francisco by mid-1987, and that 200 to 300 IVDUs will seroconvert to HIV each year through 1993.

### 3. Other Seroprevalence Estimates: Blood Donors, Military Recruits, and Anonymous Test Sites

Population-based data are not currently available for other populations in San Francisco, such as heterosexuals, infants and children, and blood transfusion recipients. To obtain crude estimates of seroprevalence in these populations, we utilized data from blood bank screening, military recruit screening, and anonymous test sites.

Figure 5 shows the proportion of seropositive blood donors among donors to Irwin Memorial Blood Bank of San Francisco. Seropositivity declined from 27 HIV positives per 10,000 tested in mid-1984 to 3 per 10,000 positives by the end of 1986. This decline reflects the impact of screening programs at IMBB and self-exclusion of high risk persons. These data are from a non-random population and are of limited utility for extrapolating to the general population. However, the estimate of 0.03% seropositive in late 1986 may be utilized as a crude estimate for the general population.

Table 10 gives the HIV seroprevalence for San Francisco military recruit applicants through March 1987. The overall seroprevalence estimate of 0.82% is based on 13 HIV positives out of 1,585 recruits tested. The estimates for the various age, sex, and race/ethnic categories must be interpreted with caution since the number tested in each category is too small for reliable estimates. The estimate of 0.82% is not representative of the general population and is probably inflated by persons in recognized risk categories (gay men, IVDUs).

Figure 6 shows the HIV seroprevalence by month for the San Francisco Anonymous Test Site (ATS) Program. Seropositivity declined from approximately 30% in mid-1985 to between 10-15% in early 1987. This decline can be attributed to an influx of low risk persons into the ATS program. This influx appeared to coincide with increased national media coverage of AIDS and of the perceived increased risk to heterosexuals. ATS data are not population-based and do not accurately reflect the true prevalence of HIV infection in either the general population or at risk groups.

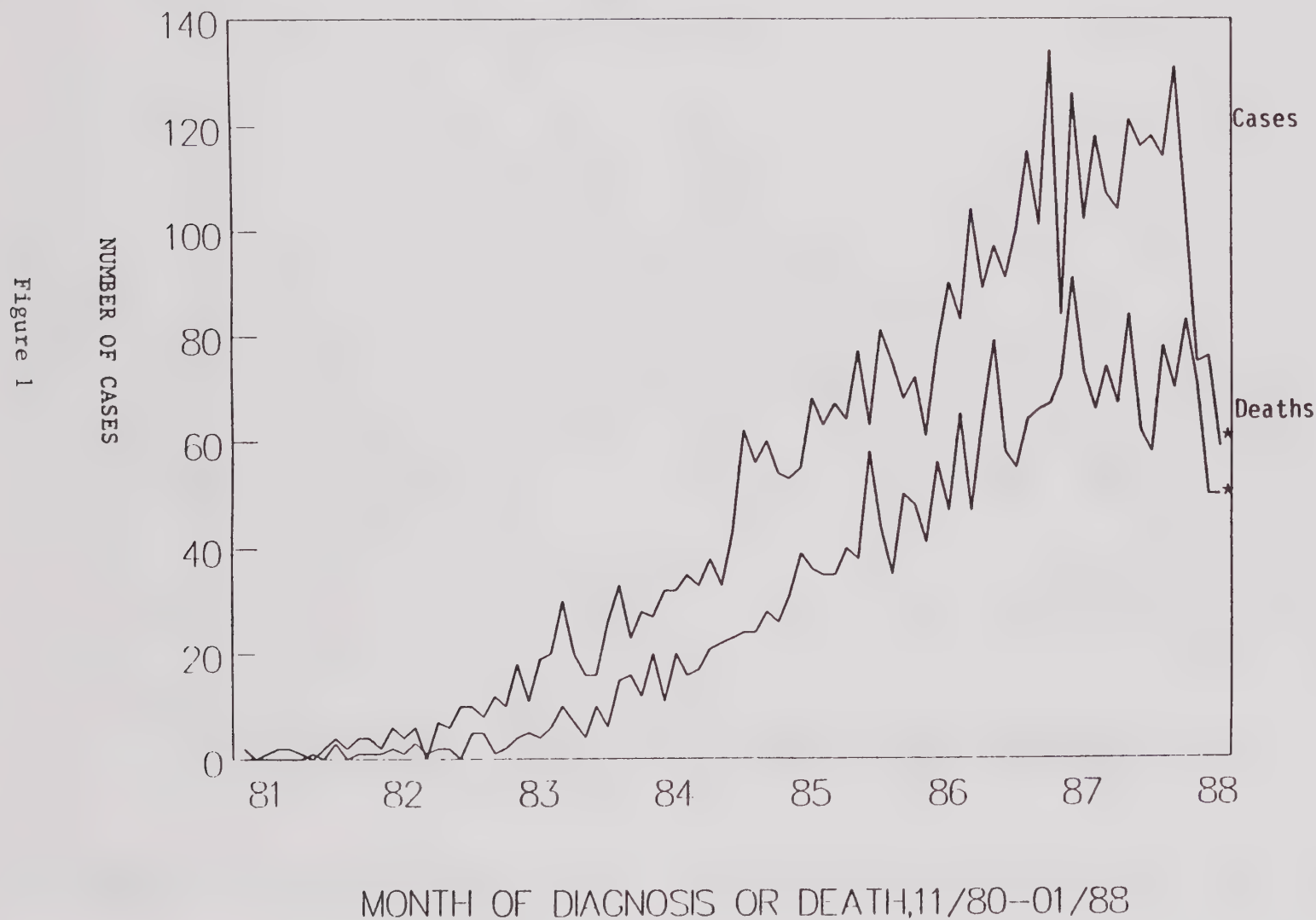
### 4. Overview of Seroprevalence Estimates

Table 11 gives an overview of the estimated seroprevalence of HIV in San Francisco and for various subgroups of the population.



# S.F. AIDS INCIDENCE AND MORTALITY

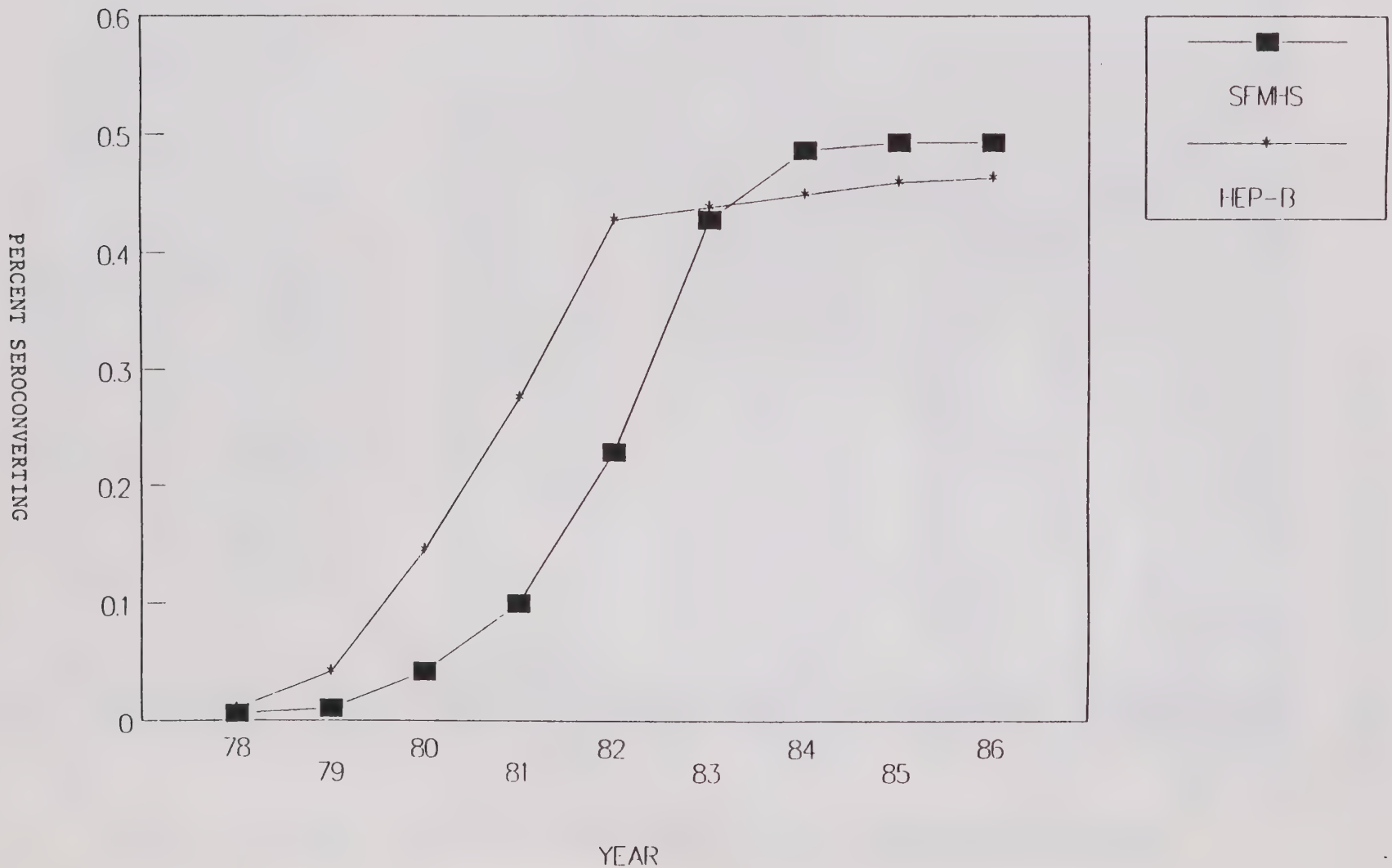
## BY MONTH OF DIAGNOSIS OR DEATH, 1980-88



\* Reporting for recent months is incomplete.

# CUMUL. PROPORTION SEROCONVERTING TO HIV

## SFMHS & HEP-B VACCINE COHORT



# PROPORTION SEROCONVERTING TO HIV BY YR

## SFMHS & HEP-B VACCINE COHORT

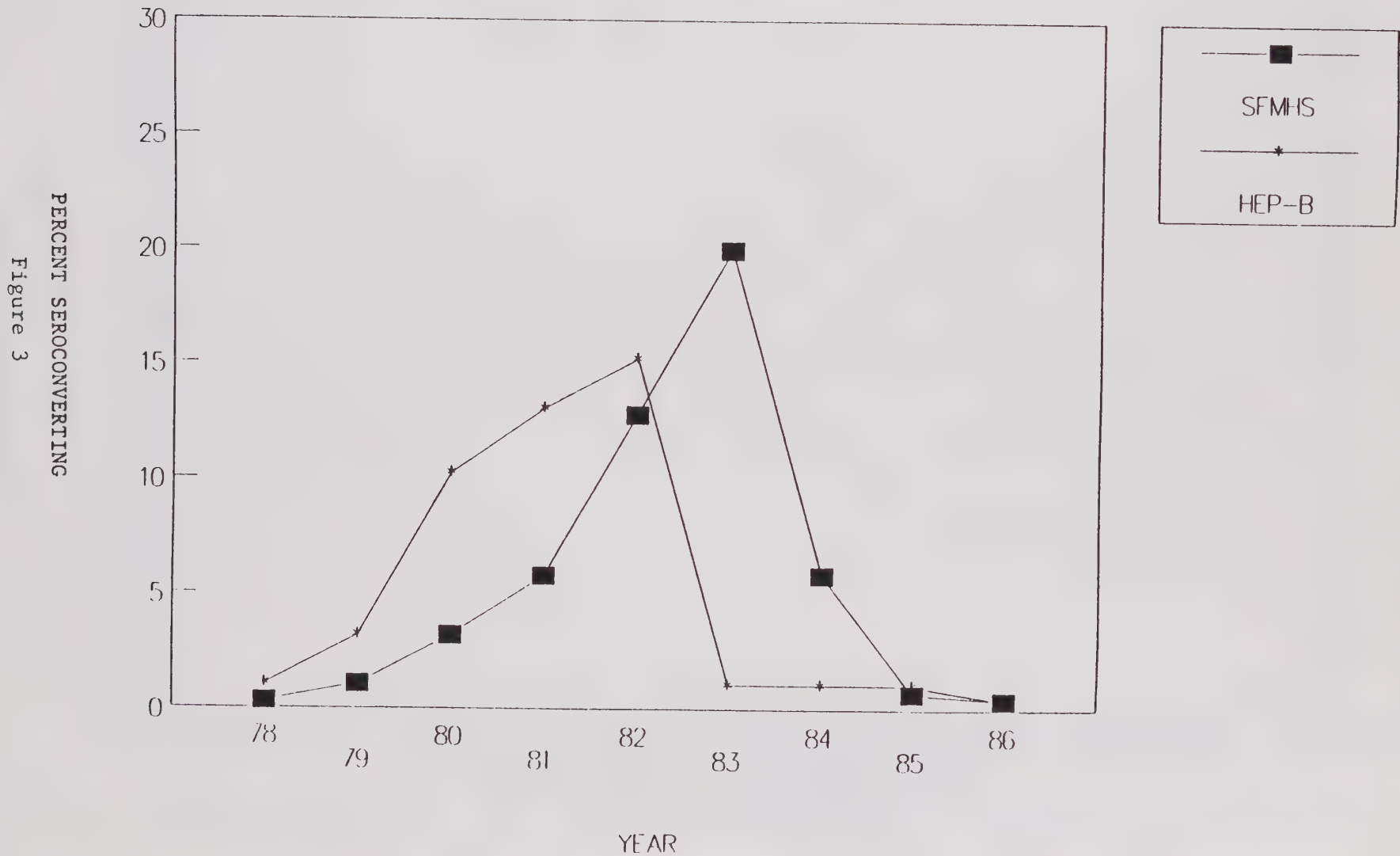


Figure 3

# CUMULATIVE HIV SEROPOSITIVITY FOR IVDUs

HETEROSEXUAL IVDUs IN SF: CHAISSON; MOSS

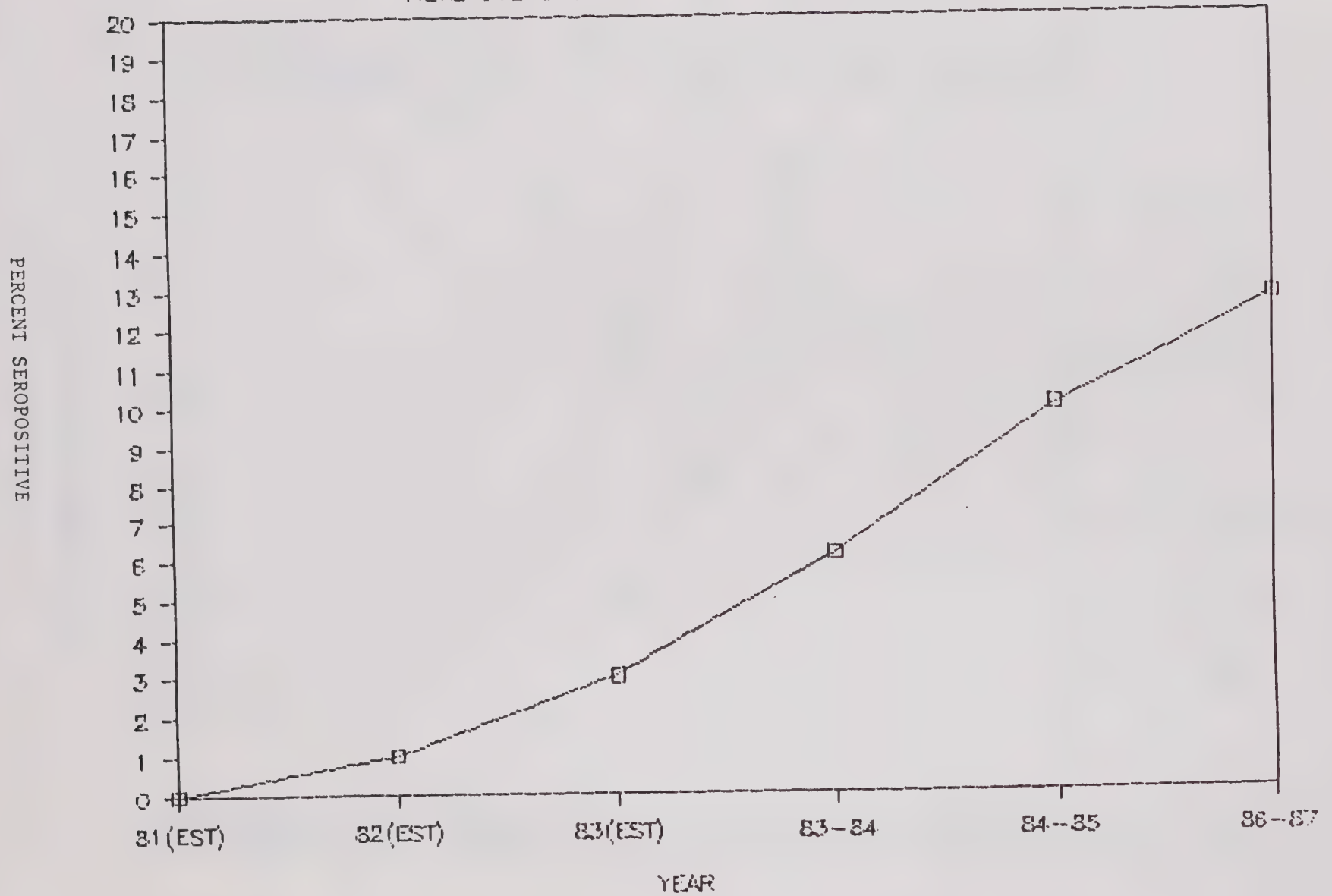
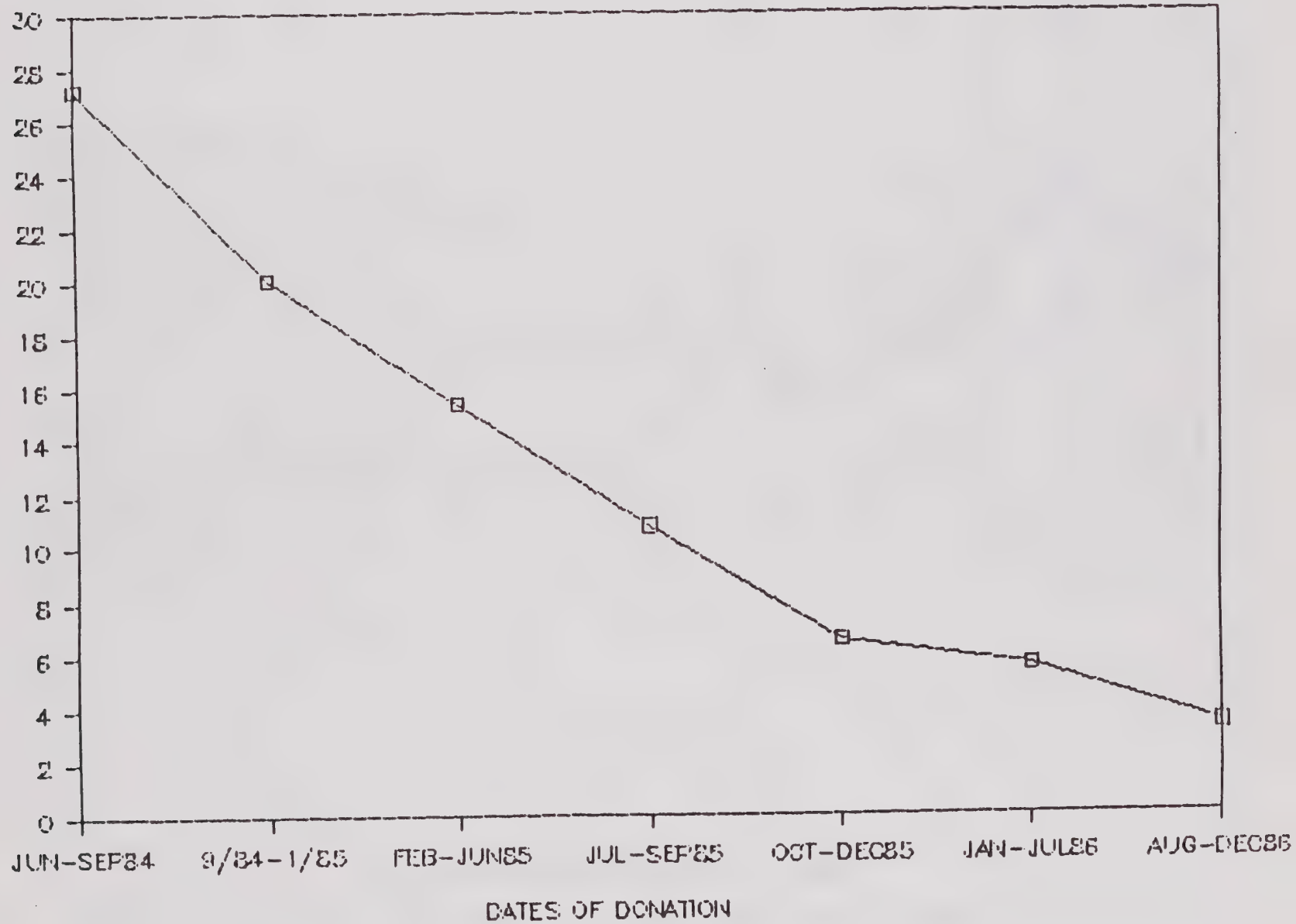


Figure 4



# PROPORTION OF BLOOD DONORS HIV POSITIVE

IRWIN MEMORIAL BLOOD BANK/SAN FRANCISCO

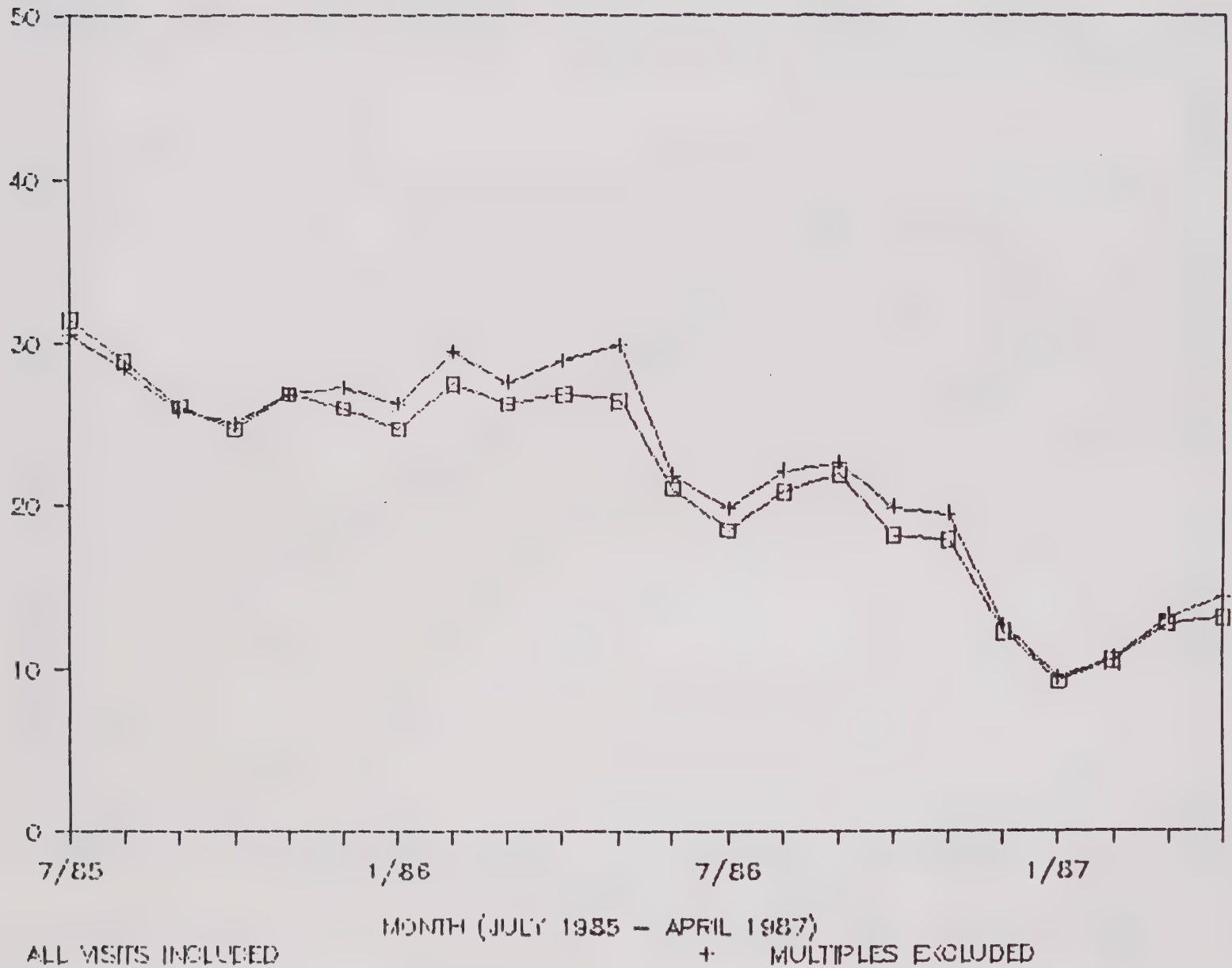


AIDS Office, SFDPH

Figure 5

# HIV SEROPOSITIVITY FOR THE ATS PROGRAM

SAN FRANCISCO ALTERNATIVE TEST SITES



PERCENT POSITIVE FOR HIV  
Figure 6

Table 1

AIDS Cases by Transmission Category and Sex, San Francisco, 1981 - 1988(1)

Transmission Category(2)	SEX				Total	
	Male		Female		N	%
	N	%	N	%		
Adult/Adolescent						
Homosexual or bisexual male	3692	85.4	0	0.0	3692	84.7
Intravenous (IV) drug User	47	1.1	15	45.5	62	1.4
Homosexual/bisexual IV drug User	520	12.0	0	0.0	520	11.9
Hemophiliac/coagulation disorder	9	0.2	0	0.0	9	0.2
Transfusion recipient	29	0.7	9	27.3	38	0.9
Heterosexual contact(3)	10	0.2	8	24.2	18	0.4
None of the above/Other(4)	18	0.4	1	3.0	19	0.4
Subtotal: Adult/Adolescent	4325		33		4358	
Children (0-12 years)						
Transfusion recipient	5	62.5	1	20.0	6	46.2
Child of high risk/AIDS parent(5)	3	37.5	4	80.0	7	53.8
Subtotal: Children	8		5		13	
Total	4333		38		4371	



Table 2

## AIDS Cases by Age Group

AGE	Cases	%
0 - 4	9	0.2
5 - 12	4	0.1
13 - 19	5	0.1
20 - 29	581	13.3
30 - 39	2174	49.7
40 - 49	1146	26.2
50 - 59	357	8.2
60 +	95	2.2
Total	4371	

Table 3

## AIDS Cases by Race or Ethnic Group

	Adult/Adolescent		Children (0-12 years)		Total	
	N	%	N	%	N	%
White	3674	84.3	7	53.8	3681	84.2
Black	282	6.5	3	23.1	285	6.5
Latino	323	7.4	3	23.1	326	7.5
Asian/Pac I.	75	1.7	0	0.0	75	1.7
Native Amer.	4	0.1	0	0.0	4	0.1
Total	4358		13		4371	

Table 4

## Asian/Pacific Islander Ethnicity(1)

Ethnicity	N	% of Asian Cases
Chinese	17	22.7
Japanese	17	22.7
Filipino	32	42.7
Vietnamese	2	2.7
Polynesian/Hawaiian	5	6.7
Other	2	2.7
Total	75	100.0

Table 5

AIDS Cases by Race/Ethnic Group and Transmission Category, San Francisco, 1981 - 1988(1)

Transmission Category(2)	Race/Ethnicity(6)									
	White		Black		Latino		Asian/Pac I.		Native Amer.	
	N	X	N	X	N	X	N	X	N	X
Adult/Adolescent										
Homosexual or bisexual male	3160	85.8	185	64.9	281	86.2	63	84.0	-	-
Intravenous (IV) drug User	17	0.5	32	11.2	10	3.1	3	4.0	-	-
Homosexual/bisexual IV drug User	449	12.2	43	15.1	24	7.4	3	4.0	-	-
Hemophilia/coagulation disorder	7	0.2	0	0.0	1	0.3	1	1.3	-	-
Transfusion recipient	23	0.6	7	2.5	3	0.9	5	6.7	-	-
Heterosexual contact(3)	10	0.3	8	2.8	0	0.0	0	0.0	-	-
None of the above/Other(4)	8	0.2	7	2.5	4	1.2	0	0.0	-	-
Children (0-12 years)										
Transfusion recipient	6	0.2	0	0.0	0	0.0	0	0.0	-	-
Child of high risk/AIDS parent(5)	1	0.0	3	1.1	3	0.9	0	0.0	-	-
Total	3681		285		326		75		4	



## AIDS Cases by Transmission Category and Year of Diagnosis, San Francisco, 1981 - 1988(1)

Transmission Category(2)	Year of Diagnosis													
	1981 - 1982		1983		1984		1985		1986		1987		1988	
	N	X	N	X	N	X	N	X	N	X	N	X	N	X
Adult/Adolescent														
Homosexual or bisexual male	122	92.4	247	85.2	461	83.2	702	83.9	1014	83.5	1099	85.5	47	79.7
Intravenous (IV) drug User	0	0.0	2	0.7	4	0.7	9	1.1	21	1.7	21	1.6	5	8.5
Homosexual/bisexual IV drug User	6	4.3	37	12.8	84	15.2	106	12.7	153	12.6	131	10.2	3	5.1
Hemophilia/coagulation disorder	0	0.0	0	0.0	1	0.2	2	0.2	2	0.2	3	0.2	1	1.7
Transfusion recipient	0	0.0	0	0.0	0	0.0	13	1.6	12	1.0	11	0.9	2	3.4
Heterosexual contact(3)	0	0.0	3	1.0	2	0.4	2	0.2	7	0.6	3	0.2	1	1.7
None of the above/Other(4)	1	0.8	0	0.0	2	0.4	2	0.2	3	0.2	11	0.9	0	0.0
Children (0-12 years)														
Transfusion recipient	0	0.0	1	0.3	0	0.0	1	0.1	1	0.1	3	0.2	0	0.0
Child of high risk/AIDS parent(5)	3	2.3	0	0.0	0	0.0	0	0.0	1	0.1	3	0.2	0	0.0
Total	132		290		554		837		1214		1285		59	

Table 7

Aids cases by year of diagnosis and race. (1)(2)

Aids cases by year of diagnosis and race. (1)(2)

Race/ Ethnic	Year of Diagnosis															
	1981		1982		1983		1984		1985		1986		1987		1988	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
White	26	86.7	88	86.3	258	89.0	493	89.0	709	84.7	1028	84.7	1029	80.1	50	84.7
Black	2	6.7	6	5.9	17	5.9	23	4.2	47	5.6	80	6.6	103	8.0	7	11.9
Latino	2	6.7	7	6.9	14	4.8	34	6.1	67	8.0	84	6.9	116	9.0	2	3.4
Asian/Pac I.	0	0.0	1	1.0	1	0.3	4	0.7	14	1.7	19	1.6	36	2.8	0	0.0
Native Amer.	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	3	0.2	1	0.1	0	0.0
Total	30		102		290		554		837		1214		1285		59	



Table 8

AIDS Cases by initial diagnosis, San Francisco, 1981 - 1988(1). Cases meeting the old case definition for AIDS

Initial Diagnosis (old definition)	N	Percent
<i>Pneumocystis carinii</i> pneumonia; definitive	2445	55.9
Kaposi's sarcoma, ( 60 yrs.; definitive	1165	26.7
Cryptococcosis, extrapulmonary; definitive	136	3.1
Non-Hodgkins lymphoma, HIV+; definitive	118	2.7
<i>Mycobacterium avium</i> complex or <i>M. Kansalii</i> disease, disseminated; definitive	65	1.5
Candidiasis of the esophagus, trachea, bronchi, or lungs; definitive	65	1.5
Cryptosporidiosis, chronic intestinal; definitive	60	1.4
Cytomegalovirus disease; definitive	52	1.2
Toxoplasmosis of the brain; definitive	25	0.6
Primary lymphoma of the brain, ( 60 yrs.; definitive	19	0.4
Progressive multifocal leukoencephalopathy; definitive	15	0.3
Herpes simplex virus infection; definitive	11	0.3
Histoplasmosis; disseminated; HIV+; definitive	6	0.1
Isosporiasis, chronic intestinal, HIV+; definitive	4	0.1
Lymphoid interstitial pneumonia/pulmonary lymphoid hyperplasia, ( 13 yrs.; definitive	2	0.0
Subtotal (old definition)	4188	95.8

Table 9

AIDS Cases by initial diagnosis, San Francisco, 1981 - 1988(1). Cases meeting the new case definition for AIDS

Initial Diagnosis (new definition)	N	Percent
HIV encephalopathy ("AIDS dementia"); definitive	45	1.0
Toxoplasmosis of the brain; presumptive	37	0.8
Pneumocystis carinii pneumonia; presumptive	31	0.7
HIV wasting syndrome; definitive	22	0.5
Cytomegalovirus retinitis with loss of vision; presumptive	12	0.3
Kaposi's sarcoma; presumptive	11	0.3
Candidiasis of the esophagus; presumptive	9	0.2
M. tuberculosis, extrapulmonary; definitive	8	0.2
Mycobacterial disease (not M. tuberculosis), disseminated; definitive	3	0.1
Coccidioidomycosis, disseminated; definitive	2	0.0
Salmonella septicemia, recurrent; definitive	2	0.0
Mycobacterial disease (unspecified species), disseminated; presumptive	1	0.0
Subtotal (new definition)	183	4.2
Total	4371	100.0

Table 10

HIV SEROPREVALENCE FOR S. F. MILITARY RECRUIT APPLICANTS

<u>CATEGORY</u>	<u>NO. HIV +</u>	<u>NO. TESTED</u>	<u>PERCENT HIV +</u>
<u>SEX</u>			
Female	1	257	0.389%
Male	12	1328	0.904%
<u>RACE</u>			
White	9	531	1.69%
Black	4	357	1.12%
Latino	0	117	0%
Others	0	580	0%
<u>AGE</u>			
17-19 Yrs.	1	633	0.158%
20-24	2	500	0.40%
25-29	3	250	1.2%
30-44	7	191	3.66%
45 +	0	11	0%
<u>QUARTER</u>			
Oct-Dec 85	0	241	0%
Jan-Mar 86	5	283	1.77%
Apr-Jun 86	2	260	0.769%
Jul-Sep 86	3	267	1.12%
Oct-Dec 86	1	237	0.422%
Jan-Mar 87	2	293	0.683%
TOTAL	13	1585	0.82%

AIDS Office, SFDPH



Table 11  
Estimated Number of HIV  
Infected Individuals in San Francisco  
through December, 1986

<u>Risk Group/ Category</u>	<u>Estimated Population Size</u>	<u>Estimated Percent Infected</u>	<u>Estimated Number of Infected Individuals</u>
Homosexual/Bisexual Men (includes gay IVDUs)	55,816*	49.3%**	27,517
Heterosexual Intravenous Drug Users	10,000	12.7%#	1,270
Adult/Adolescent Heterosexuals (excluding IVDUs)	534,454+	0.2%++	1,069
Infants and Children (<13yrs.)	78,704@	0.1%@@	80
<hr/> Total	<hr/> 678,974@	<hr/> 4.4%	<hr/> 29,936

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\* Midpoint of estimates from two surveys (42,509 and 69,122).

\*\* Estimates from San Francisco Men's Health Study.

# Estimate based on cross-sectional survey by Chaisson, Moss in 1986-87.

+ Difference between 1980 census and other categories.

++ Crude estimate based on blood bank, ATS, and military recruit data.

@ 1980 Census.

@@ Crude estimate.

## II. SURVEILLANCE, EPIDEMIOLOGY, AND RELATED RESEARCH

### A. GOALS

The general goal of AIDS surveillance and research is to collect and analyze data needed to effectively manage the AIDS epidemic. The analysis of different sets of data is important to help us better understand the many facets of the epidemic, to enable the projection of future AIDS cases and deaths, and to facilitate the planning and design of appropriate clinical, preventive, and social support programs. Surveillance data are necessary to evaluate survival trends for people with AIDS, the effects of co-factors on transmission of HIV, and progression from HIV infection to clinical symptoms. Research may provide information that answers questions about clinical manifestations of HIV infection, HIV transmission, AIDS-related knowledge, attitudes, and behaviors, and the success or limitations of current educational endeavors.

The goal of AIDS surveillance programs is to profile as accurately as possible the natural history and dimensions of the disease in our communities. The surveillance data set is used extensively for predicting future numbers of AIDS cases, AIDS-associated morbidity and mortality, and the changing nature of the epidemic. This information is necessary for planning purposes.

San Francisco provides a unique setting for such activities. In one relatively compact geographic area, there is a high concentration of patients, a community commitment to an aggressive education and prevention support program, and a large pool of talented and experienced researchers.

### B. ELEMENTS OF SERVICE

The number and variety of AIDS research projects in San Francisco has expanded considerably over the past few years. While the activity of surveillance is coordinated by the Department of Public Health with the cooperation of private physicians and hospitals, other research efforts are conducted by a broad range of individuals and institutions. Scientists conducting AIDS research in San Francisco have made an attempt to coordinate their efforts and share data as much as possible. There are at least three consortia of researchers that meet monthly to discuss their work.

For the purposes of this document, the discussion of current research efforts will be organized under the following categories:

- (1) Surveillance: In California, clinical AIDS, as defined by the U.S. Public Health Service's Centers for Disease Control (CDC), is a reportable disease. San Francisco has an "active" surveillance program, which works closely with private and public providers of medical care to ensure that data critical to our understanding of the nature and dimensions of the epidemic are collected without compromising the confidentiality of patients.

Other surveillance activities include surveillance for HIV infection in routinely screened populations, including blood donors, military recruits, and anonymous test site clients. Additionally, periodic surveys of AIDS knowledge, attitudes, and risk reduction practices are a valuable adjunct to the current system.

(2) Epidemiologic Research: Tracking patterns of HIV prevalence, incidence, and manifestations of HIV infection that do not meet the criteria established in the "surveillance definition" of clinical AIDS, and discovering risk factors associated with treatment and progression of clinical disease, are often accomplished by following carefully selected cohorts of volunteers who are representative of population groups known to be at risk for AIDS. Such studies may be either population-based or may use a pre-defined cohort. Individuals who volunteer to participate in such studies are typically tested for antibodies to HIV and interviewed at regular intervals over long periods of time. They may also have a medical evaluation at regular intervals. The data that are collected may look at seroprevalence of HIV, seroconversion trends, progression to AIDS, and/or length of survival.

Three common epidemiologic research agendas include: investigation of the prevalence and determinants for HIV infection, studies of the natural history of HIV infection in different population groups, and research that describes the clinical manifestations of HIV infection.

(3) Education and Behavioral Research: Tracking knowledge of AIDS, its transmission, and the impact of prevention education efforts on behaviors associated with transmission is also undertaken in situations where no testing for HIV infection is done. A representative sample of a targeted population group is identified and interviewed to establish what the group targeted already knows about AIDS, how its members have responded to what they know, what needs to be addressed next, and what further interventions would be appropriate. Interviews are conducted in person or by telephone. These kinds of population-based surveys are repeated annually to measure any changes in the group's responses following the implementation of specific prevention education efforts.

(4) Basic Science Research and Clinical Trials: These research efforts look at immunologic and biologic determinants and co-factors for HIV infection and HIV-related disease. In addition, studies may evaluate the effect of therapeutic interventions (e.g. antiviral drugs) on the natural history of HIV infection.



## C. CURRENT EFFORTS

### 1. Surveillance

Case reporting of CDC-defined AIDS in San Francisco is managed by the Department of Public Health's AIDS Office and depends largely on Federal funding for its operations. AIDS case reports are obtained through passive surveillance (voluntary case reporting by private physicians and hospitals), active hospital surveillance (weekly review of patient records in three high-morbidity hospitals), death certificate reviews, and validation studies. Data from seroprevalence surveys are utilized to track the distribution and trends of HIV infection in the community. Data from population-based behavioral surveys are also evaluated to identify changing behaviors which might affect the trends of HIV infection in the future.

The surveillance program of DPH follows all reported AIDS cases to determine the current health status of these individuals. These case reviews are important for determining the number of AIDS-related deaths and the number of living AIDS patients, and for evaluating changes in the survival of AIDS patients. AIDS case reports and follow-up information are entered into a computerized database, which is used for statistical analysis and for transfer of data to the Centers for Disease Control and to the California State Health Department. Computerized monthly statistical reports and quarterly hospital reports are produced and disseminated to the community.

The AIDS Office also coordinates a voluntary partner notification and antibody testing program of heterosexual partners of people with AIDS. Partner notification and related individual education are feasible in situations where the trail of transmission is relatively clear and the prevalence of infection in the population is low.

The AIDS Office collaborates with the Irwin Memorial Blood Bank to identify and notify those persons who received blood from a donor who subsequently developed AIDS. This "lookback" program is organized in such a manner that the confidentiality of the AIDS patient is not compromised. DPH staff make weekly visits to the blood bank and cross-check diagnosed cases with blood donor records. Only the AIDS Office staff member has knowledge of the AIDS patient's name. All communications with Irwin are in terms of the unit number associated with the donation. When a match is found, surveillance staff contact both the hospital and, if possible, the physician to whom the donated blood was sent, in order that they may inform the recipient.

Surrogate markers of behavior patterns also provide useful information. Where a sexually transmitted virus such as HIV is concerned, it is possible to get a general picture of changes in behavior that put people at risk for AIDS by examining data about the incidence of other sexually transmitted diseases, such as gonorrhea or syphilis.

If the incidence of rectal gonorrhea in men drops, for example, it can be taken as an indicator of a reduction in unprotected rectal intercourse

among gay/bisexual men. Since unprotected rectal intercourse is one of the more efficient ways of transmitting HIV, the data about rectal gonorrhea can serve as a "surrogate marker" of risk for AIDS. Statistics for cases of sexually transmitted diseases, such as hepatitis, syphilis, and gonorrhea, are routinely reported to and analyzed by the Bureau of Communicable Disease Control to provide valuable information about individuals who may be at increased risk for HIV infection.

DPH also conducts a study of long-term survivors with AIDS (defined as a patient living 36 months or more) to evaluate factors related to the length of survival. This study has been a part of the surveillance program since January 1987. Interviews are conducted with physicians, and chart reviews are done in hospitals and private offices to collect information on diagnoses, treatments, and laboratory tests and results of possible long-term survivors.

The AIDS Office and the Tuberculosis Control Division within the Bureau of Communicable Disease Control of DPH work cooperatively to track the incidence of tuberculosis in AIDS patients. A manual matching of cases in the TB case registry and AIDS case registry is conducted and the comparisons evaluated, looking at such variables as race, ethnicity, gender, and behavioral risk factors.

## 2. Epidemiologic Research

Between 1978 and 1980, the San Francisco Department of Public Health and the Centers for Disease Control recruited a cohort of 6,709 homosexual and bisexual men from San Francisco City Clinic, the municipal sexually transmitted disease clinic, for studies of the incidence, prevalence, and prevention of Hepatitis B. As a part of these studies, blood samples were drawn from all participants, and unused serum was frozen at CDC. Since 1983 DPH and CDC have conducted epidemiologic, clinical, and laboratory follow-up studies of this cohort to determine the incidence, prevalence, and natural history of human immunodeficiency virus (HIV). Men consenting to participate in these studies have had all previous sera and current serum specimens tested for HIV antibody, and have been interviewed and examined for clinical signs of HIV-related disease. Interviews and physical examinations include assessment for neurologic disease to determine whether neurologic dysfunction is related to HIV infection. Biological and behavioral co-factors are also being evaluated to determine their effect either on HIV infection or on the development of HIV-related disease.

In addition, the AIDS Office collaborates with two separate cohort studies that are also evaluating the prevalence of HIV infection in gay and bisexual men. A population-based study of single men, conducted by the University of California at Berkeley, monitors HIV infection rates, assesses risk factors associated with transmission, and documents the natural history of HIV disease. A prospective study conducted by the University of California at San Francisco (UCSF) and San Francisco General Hospital (SFGH) addresses similar issues.



The AIDS Office is currently in the process of coordinating a Federally funded group of seroprevalence studies in the Bay Area. This group of studies, which are being replicated across the country, will evaluate the prevalence of HIV infection in four settings where individuals who seek services are considered to be at risk of infection: family planning clinics, the sexually transmitted disease clinic, intravenous drug treatment facilities, and the tuberculosis clinic. The objectives of this family of studies include: identification of HIV seroprevalence in defined populations and of high risk behaviors for transmission of HIV infection, monitoring and evaluation of the impact of prevention efforts on HIV infection, and evaluation of changes in HIV seroprevalence in these defined populations over time.

UCSF and SFGH are managing two studies of HIV infection in intravenous drug users, one a prospective study of seropositive and seronegative individuals, and the other a seroprevalence study of participants in San Francisco methadone treatment programs. The Department of Public Health also provides consultation to the Haight Ashbury Free Medical Clinic's Urban Health Study, a street-based seroprevalence study of IV drug users.

SFGH and UCSF coordinate three separate studies evaluating HIV infection in women and assessing the behaviors that put them at risk. These studies collectively are investigating: (1) HIV seroprevalence in asymptomatic pregnant women, and HIV infection and risk for infection in a prospective cohort of seropositive and matched high risk seronegative women, (2) HIV infection rates in women in the sex industry, and (3) HIV seroprevalence in a cohort of women who have had more than five male sexual partners or who have had sexual contact with men who are significantly at risk for HIV infection.

The Western Consortium for Public Health is currently conducting a study of opposite-sex partners of people infected with HIV or diagnosed with AIDS or ARC. The purpose of the study is to examine heterosexual transmission of HIV to determine risk factors associated with transmission and the efficiency of the spread of HIV in this population.

The National Institutes of Dental Research have supported a study at UCSF that is designed to establish the nature, prevalence, and incidence of opportunistic oral disease in children and adults in the AIDS risk groups.

### 3. Education and Behavioral Research

With funding from the National Institute of Mental Health and the National Institute of Drug Abuse, the Center for AIDS Prevention Studies (CAPS) has been established to coordinate research studies that are conducted primarily in minority communities and that emphasize education for the prevention of AIDS. The focus of the Center is on developing and testing preventive interventions and on formulating and disseminating health policy guidelines.



Behavioral scientists, epidemiologists, health policy analysts, ethicists, and clinicians are among the professionals constituting the core of researchers in this program. A joint effort of UCSF, the University of California at Berkeley, Bayview-Hunter's Point Foundation, and the San Francisco Department of Public Health, this Center combines the expertise of clinical academicians, public health professionals, and minority researchers to ensure that studies are appropriate for targeted communities.

There are 13 distinct projects currently in operation or planned during FY 1987-88. Examples include: prospective studies of risk factors for HIV infection in Black, white, and Latin single men and women who live in "high risk" neighborhoods in San Francisco; studies to test the efficacy of motivational and educational programs aimed at reducing risk of AIDS among sexually active adolescents; and clinic-based outreach programs for IV drug users and their sexual partners to investigate the impact of intensive counseling, social support, and antibody testing on reducing AIDS risks. In conjunction with behavioral risk assessments, CAPS is also conducting a study of the incidence and prevalence of HIV infection in 1,500 single adults, 20 to 45 years old, in the Western Addition, Mission, and Bayview-Hunter's Point areas of the city.

The Department of Public Health, through the Surveillance Branch of the AIDS Office, contracts for surveys of different community groups to evaluate AIDS knowledge and attitudes, perception of risk, and level of risk behaviors. Such surveys are essential for designing educational campaigns that are most appropriate and effective for a specific target group.

The San Francisco AIDS Foundation has conducted four surveys of gay and bisexual men and one of heterosexuals at risk for AIDS in the past four years. Surveys of both populations are planned for FY 1987-88. Similarly, population-based surveys have been conducted by Black- and Latino-identified research teams in their respective communities. Tracking surveys of these populations will be conducted in the spring of 1988. A focus group report on needs assessment methodologies was conducted in the Asian community, and its findings will be used to implement a baseline study of AIDS knowledge and attitudes in at least three subgroups of the Asian community in 1988.

Assessment of community responses to AIDS education and of collective attitudes about AIDS and its prevention becomes difficult when the community of interest is intravenous drug users. One study that is attempting to evaluate these factors in an IV drug-using population is the Youth Environment Study. This community-based study, supported in part by the Department of Public Health and the National Institute of Drug Abuse, in collaboration with the AIDS Office of DPH, uses ethnographic methods to look at knowledge about AIDS and its transmission, drug-using and needle-sharing patterns, and sexual behaviors that put these individuals at risk. Identification of the social and psychological factors that undermine compliance with recommended prevention methods is also an important part of this research.

#### 4. Basic Science Research and Clinical Trials

The Department of Public Health and UCSF have received funding from the State of California to build a research center at San Francisco General Hospital. Planning for this center is in progress.

Researchers at the University of California at San Francisco and San Francisco General Hospital are involved in a variety of basic research studies to unravel the mysteries of the AIDS virus and to develop effective therapeutic interventions. The National Institutes of Health (NIH) granted a five-year award of over \$4 million to the Schools of Medicine and Pharmacy at UCSF to develop drugs to fight AIDS. In addition NIH has provided over \$9 million for a project that looks at ways to prevent the transmission of AIDS through the blood supply. The project includes an analysis of the reliability of current AIDS antibody tests and research to develop new screening tests that detect the actual AIDS virus rather than antibodies.

The Department of Public Health, UCSF, SFGH, and the Veterans Administration Medical Center, Pacific Presbyterian Medical Center, and San Francisco Kaiser Hospital conduct clinical trials of new treatments (including zidovudine and ribavirin), and new approaches with existing treatments, such as aerosolized pentamidine. Currently, there are 22 clinical protocols in place at San Francisco General, which should enroll approximately 750 patients during FY 1987-88.

The Veterans Administration Medical Center participates in a national AZT double-blind study with four other veterans' hospitals. In addition they currently enroll a total of approximately 100 patients in a variety of experimental treatment protocols.

#### D. FACTORS INFLUENCING THE DEVELOPMENT OF SURVEILLANCE, EPIDEMIOLOGY, AND RELATED RESEARCH

The impact of the revised surveillance definition

1. The U.S. Centers for Disease Control (CDC) recently expanded the definition of reportable AIDS cases to include the more severe forms of what are often termed AIDS-related conditions. The new definition became official in September 1987. This mid-course change in definition not only generated a "blip" in the pattern of cases reported but also increased the ongoing responsibilities of those providing surveillance services by approximately 20%.
2. For some who are very ill, a beneficial spin-off of this definition change will be easier access to entitlement programs for the disabled.
3. Its recent expansion notwithstanding, the surveillance definition of AIDS still only identifies relatively advanced clinical



manifestations of HIV infection. These are the only manifestations of the disease that are reportable at this point. Some view this limitation as hampering efforts to gauge the size and scope of the overall problem of HIV-associated disease.

#### Reporting issues

4. There seems to be increasing political pressure to require the reporting of AIDS-related conditions or AIDS-related complex (ARC) and HIV infection, in addition to cases of clinical AIDS. In practice, such a requirement would be difficult to accommodate (ARC is a poorly defined circumstance) and costly to implement (depending on the definition used, the number of cases handled by surveillance teams could easily double or triple).
5. There is also some pressure to require HIV antibody testing in a variety of circumstances (when people apply for marriage licenses, health insurance, life insurance, certain kinds of jobs, etc.) and reporting of names of all who test positive. The financial cost of implementing such a program could, depending on the circumstances in which it was required, be extremely high.
6. In general, proposals to increase reporting tend to aggravate legitimate concerns about the threat of discrimination against those whose names are reported. While most epidemiologists agree that more accurate data about the incidence and prevalence of HIV infection and disease could be extremely useful, data based on reports of HIV infection or ARC would not necessarily be accurate. That is, as the early symptoms of HIV infection are often difficult to diagnose, there would likely be significant underreporting of these conditions. Perhaps more significantly, there is a high potential for driving infected people underground and away from participation in studies of the development and spread of the disease. Such proposals also exacerbate the tendency of many to blame transmission entirely on those infected.
7. The usually long period between infection with HIV and the development of symptoms which can be traced to HIV infection has complicated the problem of tracking this disease. Strategies such as contact tracing are not generally regarded as useful. While contact tracing and partner notification may have some small impact in preventing perinatal and sexual transmission of HIV, the long incubation period means that many individuals are "lost to follow-up", making contact tracing an expensive endeavor.

#### Need for rigorous confidentiality

8. Questions about ensuring confidentiality have emerged around AIDS, making it necessary to limit use of the antibody test to situations in which subjects' identities can be particularly well protected.

Research studies conducting antibody testing are obligated to provide all possible safeguards for the protection of their volunteers.

Cost issues

9. Prospective studies (i.e. studies built around a representative cohort to be followed over a long period of time) are extremely expensive and traditionally have depended on Federal funding for support.
10. The Centers for Disease Control have recently adopted a policy of limited funding for AIDS case surveillance while increasing Federal funding of HIV seroprevalence studies. As the number of AIDS cases continues to grow, the Federal government will require local jurisdictions to assume a larger portion of the financial burden for collecting and reporting AIDS cases.
11. Population-based surveys of risk group knowledge, attitudes, and behaviors among the particular groups at risk for AIDS (e.g. gay/bisexual men, IV drug users) are extremely useful in the development of effective education programs. The California Department of Health Services (DHS) has been inconsistent in its appreciation of the need for such surveys. The Federal Centers for Disease Control, on the other hand, have been more willing to grant sufficient allocations for them.
12. In 1985, the State of California enacted legislation that provided funding for AIDS education services to be delivered by a statewide system of information and education contractors. A component of this law mandated an evaluation of these education programs. This evaluation was completed in the summer of 1987, and one of its major recommendations was that DHS continue to support AIDS education research and evaluation activities, and design a focused research agenda. The authors suggested some promising directions for additional research, including: a longitudinal assessment of the long-term behavior changes resulting from different education interventions, an analysis of the effectiveness of indigenous community institutions as providers of AIDS education and prevention messages, a rigorous analysis of behavioral risk factors for HIV infection, etc.

E. POLICY REAFFIRMATION

1. DPH reaffirms its commitment to conduct surveillance of HIV infection and to conduct research in order to develop and evaluate policies designed to prevent the spread of HIV infection.
2. DPH reaffirms its commitment to maintain a structured and accurate surveillance system, including a routine evaluation of the effectiveness of the various components of this program.



3. DPH reaffirms its commitment to careful behavioral and serologic assessments of populations targeted for education and prevention support programs to maximize the effectiveness of these programs.
4. DPH reaffirms its commitment to evaluate educational, behavioral, and therapeutic research efforts on an ongoing basis and to disseminate the results in order that the most effective prevention and treatment approaches are known to public health and clinical practitioners in San Francisco.
5. DPH reaffirms its commitment to evaluate substance abuse and other treatment interventions as well as educational strategies in order to determine the most cost efficient systems of care.
6. DPH reaffirms its commitment to ensuring that the confidentiality of client/participant records associated with these surveillance and research activities will be scrupulously protected.

### III. PUBLIC EDUCATION

#### A. GOALS

The purpose of AIDS education for the general public is to stop the spread of HIV infection and to create an environment in which appropriate health care and support services for those already infected are developed. Education for the general public in this context includes efforts targeted at all segments of the population: both individuals who are at high risk and those who are not. Broad goals include:

- a. fostering awareness about the transmission of AIDS and how individuals can protect themselves and others from infection;
- b. demystifying AIDS and in consequence reducing hysteria about casual transmission;
- c. fostering awareness among the HIV infected, asymptomatic population about the importance of health-promoting behaviors and the availability of sound medical options; and
- d. fostering an understanding of the dimensions of the problem, its complexity, and the potential costs (in terms of lives, emotions, and dollars) so that support for constructive and cost-effective services will be forthcoming.

The goals of AIDS education designed to enable people to change behaviors that put them at risk for HIV infection are based on the realization that, in order for sustained behavioral change to take place, individuals must develop attitudes and beliefs conducive to continuous observance of these new behaviors. Several social science models articulate variables important in the development of health-related attitude and behavior changes. The models of Rosenstock and Hochbaum (Health Belief Model), Azjen and Fishbein (Understanding Attitudes and Predicting Behavior), and Bandura (self-efficacy theory of behavior change) are some of those incorporated in this discussion. Educational efforts are designed to address one or more of these variables in the attempt to foster attitude and/or behavior changes. Behaviors which constitute risk for HIV infection are addressed within the broader social and cultural context in which they occur. The Department supports behavioral change strategies that are consistent with the social and cultural milieu of each target audience.

The goals of AIDS education targeted to those already infected are similar to those of programs focused on preventing transmission of the infection. Support for behavior changes is essential to ensure no further transmission. Asymptomatic but HIV positive individuals are a special subset of this target population. Appropriate education directed toward their

concerns can prevent later health, psychological, and economic problems. In addition to the goal of preventing further HIV transmission, the goal of education for these individuals is to help them maintain their health by providing accurate and timely information focusing on (1) health-promoting behaviors (reducing stress, sensible diet, adequate rest, and exercise), (2) accessing health care, (3) the importance of seeking care early, and (4) the available medical options including experimental therapies.

## B. ELEMENTS OF SERVICE

AIDS education services can be categorized in a variety of ways which are not mutually exclusive. In order that reviewers may appreciate the depth and breadth of AIDS education in San Francisco, this chapter presents a discussion of various ways of looking at elements of service in more detail than in other chapters. The discussion will proceed under the following headings:

- (1) Target Audiences
- (2) Educational Approaches
- (3) Conceptual Framework
- (4) Content

### 1. Target Audiences

General education is targeted to everyone, including groups defined by the level of risk associated with their behaviors. Prevention education is targeted to groups whose behaviors are assumed to put them at particular risk. Audiences can be described in other ways which do not result in mutually exclusive groups. They include:

- a. The general public: everyone.
- b. Groups defined by behavior: men who have sex with other men, IV drug users/needle sharers, people whose sexual behaviors are disinhibited by substance use, people with multiple sexual partners, sexual partners of the aforementioned groups, sexual partners of people infected through blood transfusion/blood products, etc.
- c. Groups defined by community: people whose primary "community" is defined by their race or ethnicity, gender, sexuality or sexual orientation, age group, etc.
- d. Groups defined by the place they are available to be educated: jail inmates, youth in school, consumers of health services, patrons of a soup kitchen, employees, members of a church, community group, or social organization, etc.



## 2. Educational Approaches

There are a variety of approaches available for reaching and communicating to the general public as well as to more narrowly defined target audiences. The description of each approach here is not meant to imply that one is sufficient or independent of any other. Although the strategies are listed in an order which reflects increasing individual involvement and confrontation, it does not necessarily follow that target audiences will experience each or that an intended response is contingent on any particular order of experiences.

Each approach should be reviewed with the understanding that its usefulness will undoubtedly vary among groups with different lifestyles or cultural heritages. Some, for example, may value the distance and anonymity provided by a telephone information service; others may be suspicious of the reliability of any information not secured in a face-to-face encounter. It is suggested, however, that with appropriate sensitivity to the issues of who delivers the messages and how they are framed and communicated, some combination of the strategies listed below will be used in any successful education program. Where general education ends and prevention support begins in this process depends on the individual's perception of risk and his or her ability to absorb and utilize risk reduction information.

The list includes: (a) strategies for promoting awareness among both general and specific populations, (b) telephone access to more specific information or resources, (c) opportunities to observe and perhaps participate in public dialogue, (d) opportunities to participate in small group dialogue, and (e) individual and small group counseling/support for behavior changes.

- a. Media advertising: brief messages designed to reach large numbers of people. Advertisements are placed in general circulation newspapers and magazines and in specialized outlets (e.g. community newspapers). Transit ads, billboards, and TV and radio spots are also used.
- b. News and feature coverage: stories which enhance audiences' general awareness and understanding of the health concerns associated with the AIDS epidemic.
- c. Pamphlets, videos, and collateral materials: materials developed for distribution via mail and street intercepts, at public forums, and through health care facilities. Specific messages and target populations vary. Most are printed and can be carried away; some are video presentations. Several forms of media advertising can provide a link to printed and video materials designed for individuals who cannot read or who read with difficulty.
- d. Telephone information and referral services: an information clearinghouse to respond to questions stimulated by other prevention education programs and to give referrals to persons



wishing to make use of other educational or service resources. Telephone services provide caller anonymity and easy access to comprehensive and accurate information.

- e. Forums, workshops, and classes: typically one-session group training events which reinforce the basic messages of other education efforts and include panel discussions, lectures, video presentations, and opportunities for getting brief answers to questions. These events may be facilitated by health or education professionals. Another strategy often employed is the use of volunteers with AIDS or ARC, sometimes in combination with other professionals, to conduct classes or present workshops. This has been shown to be a very effective method of imparting AIDS prevention messages to certain groups.

The specific subject matter and focus of these events vary depending on the audience. Some of these events are initiated by the provider; some are offered in response to requests from participant groups. As an example, Shanti and the San Francisco AIDS Foundation both organize speakers who are available to speak to groups on request.

- f. Interactive peer groups: formalized peer support groups established to foster acquisition and retention of new health behaviors. Peer support groups range from those which are explicitly labelled and professionally facilitated to those which provide informal, non-directive support through group participation in volunteer work with AIDS organizations.
- g. Individual health education and counseling: one-on-one and face-to-face discussion of issues related to AIDS prevention. The most widespread example of education at this level is the interaction that occurs when clients of the anonymous antibody testing program receive their test results. Since the testing in this setting is not done in the context of a more general medical examination, it is valued more as an opportunity for education than clinical screening. The "line" between health education and mental health support (therapy) in such situations is not necessarily a distinct one, although it is sometimes convenient to discuss the distinction as a function of time and number of sessions.

### 3. Conceptual Framework

In developing its AIDS prevention program, DPH has used as a basic reference a list of factors identified in early planning sessions by San Francisco psychologist Steven Morin, Ph.D., as generic contributors to health-related attitude and behavior changes. The contributing factors, which Morin drew from the literature on behavior change, include:

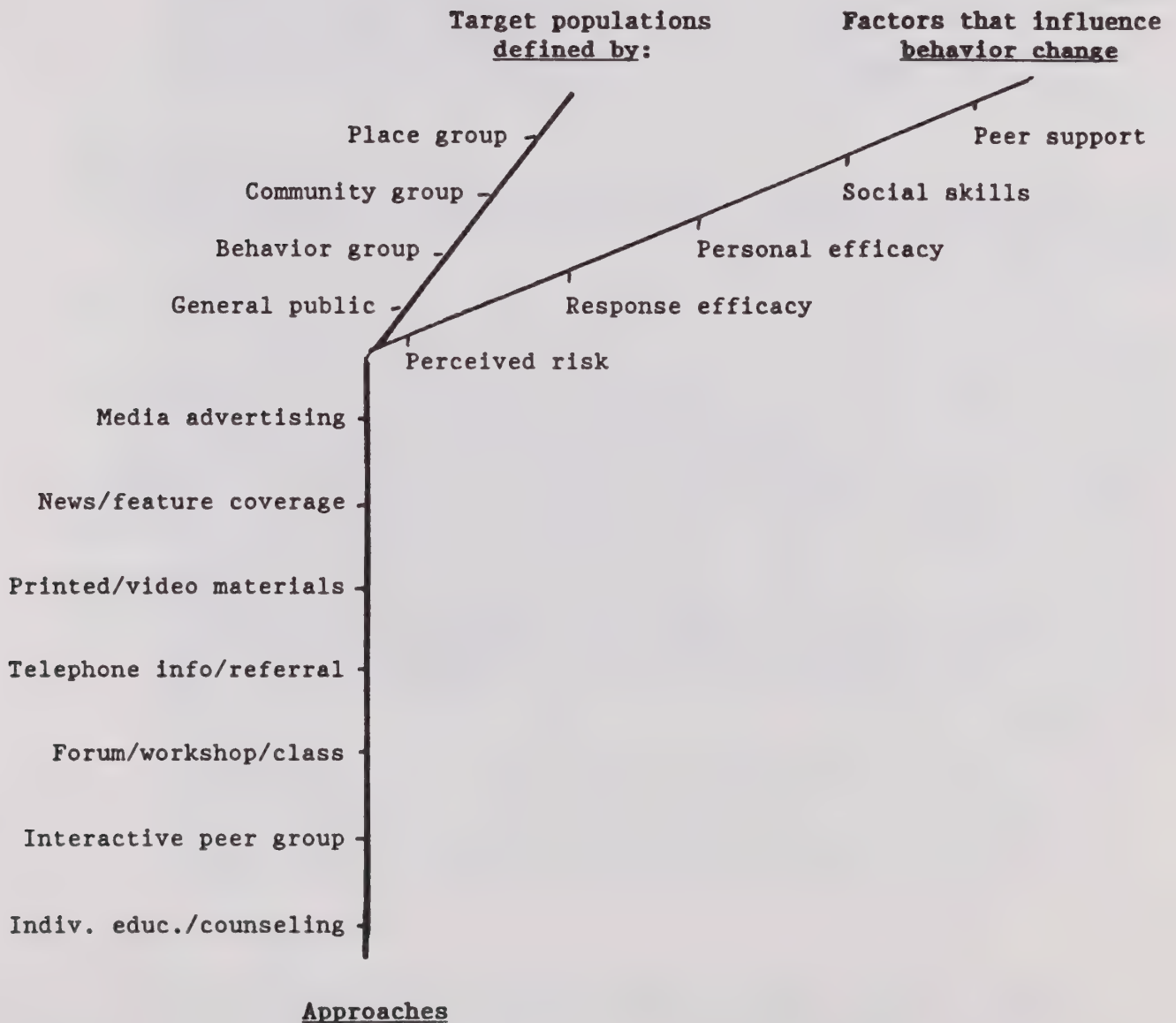
<u>Generic expression</u>		<u>AIDS-specific expression</u>
Perceived risk	-	AIDS is a threat
Response efficacy	-	AIDS is avoidable
Personal efficacy	-	AIDS can be avoided without seriously compromising one's values or satisfaction with one's life
Social skills	-	New behaviors required for AIDS prevention are do-able
Peer support	-	The community supports these new behaviors

A number of successful efforts to change health-related behaviors have been built around this model. One of the most dramatic was undertaken by researchers at Johns-Hopkins University to control hypertension among Black men in Baltimore, MD.

In San Francisco, however, and with regard to AIDS, the model has been used primarily as a reference: it provides the third dimension of the framework against which the various pieces of the AIDS education continuum have been placed and through which their relationship to one another has been better understood. It has been our experience that every AIDS-specific education program can be described as a program that addresses one or some combination of these contributors to behavioral change. Some find it more convincing to talk in terms of lowering barriers to behavioral change rather than contributing to it, but either perspective can serve to define the third dimension. They are, in effect, mirror images of one another. Target audience and approach employed make up the other axes of the three-dimensional grid. Each AIDS education program may be viewed as a "box" or series of "boxes" defined by these three dimensions. The content of each box is tailored to the circumstances created by the intersection of the three dimensions.

Figure 1 is a schematic drawing of the three-dimensional grid:

Figure 1.





#### 4. Content

San Francisco's AIDS education programs are, whenever possible and appropriate, built on the foundation of quantitative and qualitative assessments of audiences targeted. Quantitative assessments (population-based surveys) help to determine what audiences already know and believe, how they have responded to what they already know, and what strategies will have the greatest likelihood of success. They may also include seroprevalence and incidence studies of target populations. Qualitative assessments (often using focus groups representative of target populations; in some instances using ethnography or participant observation) help to shape quantitative surveys as well as determine the likely impact of approaches to particular target audiences. These assessments are discussed in much greater detail in the chapter on Surveillance, Epidemiology, and Related Research.

DPH-associated educational programs follow the general principles that (a) all messages should be consistent with the latest developments in epidemiological and medical knowledge of AIDS and its transmission and (b) messages should be conveyed through a medium (print, pictures, oral/aural), in language (visual, verbal), and in a setting which the targeted audience will be able to understand, will find appropriate, and to which it will respond. Specific messages, however, will be varied. In this instance, "message" is used in its broadest sense: what is said explicitly as well as what is implied by the medium, the messenger, etc. Important determinants of message content include:

1. Who is targeted: the group or community "identity" of the audience targeted and the social and cultural value systems associated with that identity.
2. What they already know/believe: the health beliefs of the audience.
3. What exposure the audience has already had: what is already available through audio, visual, and personal resources.
4. What literacy/education levels can be assumed: the level of education, literacy, and language capability of the audience addressed.
5. What media are used: print, pictures, oral/aural.
6. What levels of formality and intimacy to which the audience will respond.
7. Who is delivering the message: their status in the community, their relationship to the audience, etc.
8. What generic contributors to health-related attitudes and/or barriers to behavior change are being addressed.



9. What is the particular goal of the educational intervention: what the strategy is expected to accomplish.
10. What resources are available: what is feasible given the setting and funding constraints; what others are doing.

### C. CURRENT SERVICES

Since current service budgets are generally organized around cost centers defined by educational approach, the following discussion is organized around educational approaches. Education services associated with HIV antibody testing will be discussed at some length in the section on individual health education and counseling. Education services that target substance abusers and whose principal link to DPH is through Community Substance Abuse Services (CSAS) are discussed in the chapter on Substance Abuse Services.

#### 1. Media Advertising

The San Francisco AIDS Foundation (SFAF) develops brief educational messages to be used for display on public transportation vehicles, on billboards, in community newspapers, and in radio advertisements. Such mass media efforts are specifically designed to complement community level education and are directed at specific populations. For example, in FY 1987-88 approximately 50 advertisements in gay-identified community newspapers and magazines will be targeted for gay and bisexual men, 60 billboards will be posted targeting IV drug users, 20 advertisements will be run in community print outlets that address concerns of women, and over 100 radio advertisements will be run targeting racial/ethnic minorities.

DPH's own Division of Community Public Health Services funded the development and marketing of public service announcements with AIDS prevention messages on community radio stations. These brief announcements (30-60 seconds each) are available in English, Spanish, Cantonese, Tagalog, and Japanese and are designed to address the concerns of racial and ethnic minority youth and adults. In addition, the winning entry in San Francisco's Rap'n Contest (a contest designed to engage San Francisco youth in AIDS prevention education during 1986-87) has been produced as a public service announcement.

A community-based multi-ethnic radio station, KP00-FM, with support from the U.S. Conference of Mayors, targets inner-city Black and Latino communities with regular programming focused on AIDS issues. For FY 1987-88 education efforts through this medium include routine public service announcements in both English and Spanish.

Advertising that is specifically designed to promote awareness of the anonymous HIV antibody testing program is discussed in more detail in the section devoted to that program.

## 2. News and Feature Coverage

Since 1984 both the San Francisco Department of Public Health and the San Francisco AIDS Foundation have employed liaisons to work full-time with print and electronic media to promote accurate and constructive coverage of the AIDS epidemic. This coverage includes stories in newspapers and radio and television news broadcasts, panel discussions on radio and television specials, as well as representation on talk shows and documentaries. The liaisons work closely with reporters, editors, and producers to facilitate access to factual information and to public health and medical authorities who have thoughtful insights regarding the implications of new information and events.

In 1987, media liaison was also identified as a specific responsibility of AIDS education staff at the Bayview-Hunter's Point Foundation (Multicultural Alliance for the Prevention of AIDS: MAPA), Instituto Familiar de la Raza (Latino AIDS Project), and Asian-American Recovery Services (Asian AIDS Project). Each organization has undertaken to promote responsible coverage of AIDS issues in media outlets that target the racial/ethnic minority communities with which it is most closely identified. All three are also involved in helping "mainstream" media appreciate and reflect the fact that all communities in San Francisco are at risk for and affected by AIDS.

SFAF alone expects to initiate or respond to at least 1,350 media contacts during FY 1987-88. Approximately 15% of this outreach will be directed to racial and ethnic minority communities. At the beginning of the fiscal cycle, MAPA, the Latino AIDS Project, and the Asian AIDS Project each projected from 50 to 230 contacts during the year, but each achieved or nearly achieved its annual objective by the end of the second quarter.

KPIX - Channel 5 has initiated a prize-winning public service campaign called "AIDS LIFELINE", which includes regularly aired panel discussions and documentaries on issues relevant to AIDS prevention as well as the care and support of persons with AIDS/ARC. KBHK - Channel 44 has also had a series of special programs devoted to AIDS.

As was mentioned in the section on "Media Advertising", KP00-FM, under its contract with the U.S. Conference of Mayors, targets inner-city Black and Latino communities with regular programming focused on AIDS issues. For FY 1987-88 education efforts through this medium include panel discussions with AIDS experts and community representatives that encourage listeners to call in with questions, and the airing of theater pieces, in both English and Spanish, that address AIDS risk reduction.

## 3. Pamphlets, Videos, and Collateral Materials

Existing educational pamphlets, videos, posters, and resource guides target diverse groups of people, including women, gay/bisexual men, racial/ethnic minorities, IV drug users, sexually active individuals and their



partners, others at risk, and the general population. Printed materials have been designed to introduce or reinforce audience-specific information about risk and risk reduction, suggest resources for further information and/or individual support, or identify health care and related services that have a particular focus on HIV infection and AIDS.

DPH contractors and in-house services which have developed AIDS education materials are expected to review their products regularly for consistency with developments in epidemiology and clinical practice regarding AIDS as well as with the results of periodic assessments of the knowledge and beliefs of audiences targeted. Some materials have been reprinted or reissued in their original form several times since they were first released. Others have been revised before being reissued. New materials are developed as new issues are raised and/or more discretely defined audiences are targeted. The AIDS Office has established a formal internal review committee that reviews new and revised materials for both accuracy and general acceptability.

It is expected that, in general, all materials developed by AIDS education programs associated with DPH will be shaped in response to a careful assessment of the attitudes and beliefs of the audience targeted. It is also expected that draft materials will be field tested before publication, at least with a "focus group" carefully drawn from the audience targeted.

The San Francisco AIDS Foundation (SFAF), under contract with DPH's AIDS Office, produces more AIDS education materials, in terms of both volume and variety, than any other organization in San Francisco. Many of its efforts are designed to complement the "campaigns" of the Foundation's other educational cost centers, but some are also developed to support the educational outreach of other organizations in the city (for example, the Forensics AIDS Project, DPH's anonymous HIV antibody testing program, activities of community substance abuse services, etc.). SFAF publishes a catalog of AIDS educational materials, including pamphlets, flyers, comic books, manuals, posters, etc., that provide information on issues ranging from safe sex guidelines, the relationship among alcohol, drugs, and AIDS, to risk reduction for male and female sex workers. Under the terms of its 1987-88 contract with DPH, the SFAF materials development and distribution program will distribute 800,000 units during the year in San Francisco at no cost to the recipients.

The Foundation's materials are often available in Spanish, Chinese, and Tagalog as well as English. They are distributed upon request at Foundation-sponsored workshops and forums and through the catalog, as well as at a network of community distribution sites whose stocks are routinely replenished.

DPH's own Forensics AIDS Project, with technical and production assistance from SFAF, produces materials specifically for use in the jails, including posters and pamphlets designed for this population. Every inmate entering the San Francisco jail system receives an AIDS risk reduction message either verbally or in print.



Other programs within DPH, such as the Bureau of Communicable Disease Control and San Francisco City Clinic, have produced brochures for specific purposes. For example, 25,000 copies of a brochure titled "Can I Get AIDS in School?" and 100 condom posters will be distributed during 1987-88.

AIDS education materials targeted for racial and ethnic minority communities have been developed by the Multicultural Alliance for the Prevention of AIDS (MAPA) and the Latino AIDS Project. Both of these organizations received funding directly from the California Department of Health Services (DHS) in 1986-87 to produce and distribute linguistically and culturally appropriate materials to San Francisco's Black and Latino communities, respectively. DHS funding which supports the extension of these efforts into 1987-88 is administered through contracts between DPH and the two community-based providers. The Asian AIDS Project expects to distribute 4,000 brochures during FY 1987-88.

Under a competitively bid contract with the DPH AIDS Office, Multicultural Prevention Resource Center (MPRC) has developed four videos and supporting printed materials for the Black, Latino, Chinese, and Vietnamese communities regarding the anonymous HIV antibody testing program. The use of these materials will be discussed in further detail later in this chapter.

#### 4. Telephone Information and Referral

The San Francisco AIDS Foundation (SFAF) recruits, trains, and supports approximately 200 volunteers who operate an AIDS Hotline open 72 hours a week. It is a resource for people who are HIV infected and asymptomatic or ill with AIDS/ARC as well as for those seeking information about AIDS risk, transmission, and prevention, or AIDS antibody testing. The hotline receives 4,000-6,000 calls each month from residents of San Francisco. Beginning in November 1987, Spanish-language capability has been available for all hours that the hotline is open, and there is regular training of the hotline volunteers about potential culturally specific concerns of callers.

Although the SFAF hotline itself does not yet provide regular services to callers who speak neither English nor Spanish, SFAF's contract with DPH also addresses the need to identify a community-based organization in each major language group to whom callers needing that language capability can be referred. SFAF staff have undertaken to train agency staff to handle such calls. SFAF is actively recruiting volunteers who are fluent in languages other than Spanish and English.

The SFAF hotline equipment includes a TDD hook-up for the deaf.

San Francisco residents concerned about AIDS may also access the DPH-funded Suicide Prevention Services hotline (funded through Community Substance Abuse Services) for support. Volunteers and paid staff of this hotline have received special training regarding AIDS. Both report that the number of AIDS-related calls is increasing.

Similarly, the National AIDS Information Hotline and Information Center, based in Research Triangle Park, North Carolina, and managed by the American Social Health Association, provides timely information nationwide, on a 24-hour basis. Both the national and SFAF hotlines keep up-to-date with the most current AIDS information. While the national line is limited to generic AIDS information, SFAF has the ability to make very specific referrals to providers and services all over Northern California.

Project Inform, a non-profit community agency, provides information on available experimental therapies for people who are HIV positive or have AIDS/ARC. Project Inform operates a daily hotline and collects and distributes materials related to available drugs and other treatments. It receives approximately 2,000 calls each month, 25 percent of which are from California alone.

Finally, it should be noted that all AIDS service organizations and divisions of the Health Department (e.g. Disease Control, the Patient Education and Resource Center at SFGH, District Health Centers) receive and handle calls for general information about AIDS and referral to AIDS services, even if they are not specifically funded to do so.

## 5. Forums, Workshops, and Classes

### General

The San Francisco AIDS Foundation serves as a centralized resource which provides speakers and coordinates AIDS educational events for a wide variety of groups. It maintains a speakers bureau of individuals who are carefully trained and supervised by AIDS Foundation staff. These speakers provide easy-to-understand, specific, detailed information about AIDS to groups ranging from employees at Esprit Corporation or a social service agency to members of a gym or recreational club. Programs are tailored to fit their audiences. Some provide basic or more advanced medical information about AIDS, while others focus on issues of infection control, casual transmission of HIV, the emotional issues of working with someone who has AIDS, etc.

SFAF will also produce educational events this year on its own initiative, in conjunction with coordinated media and materials distribution campaigns the Foundation will undertake. Examples of these proactive events include: one-day conferences for health providers on gay male health, booths at neighborhood street fairs, safe-sex workshops, and workshops conducted in community settings such as health clubs. Special efforts are made to ensure that educational events coincide with other community activities and in community settings that are likely to attract audiences at high risk or with a special need for AIDS education.

Taking the reactive and proactive events together, SFAF is expected to organize 390 events in 1987-88. Numbers of participants are expected to range from 15 to 100, with an average of 35.



The Asian AIDS Project, under contract to DPH's AIDS Office, undertakes AIDS prevention efforts that are specifically targeted to different cultures within the Asian community. The program includes the development and coordination of educational events, with an emphasis on raising the consciousness of community leaders about AIDS and its threat to their respective communities. AAP projects working with 396 community leaders and educators in and with 220 other contacts in 1987-88.

Shanti Project also provides speakers and organizes educational events for interested groups.

In addition, various other subdivisions of DPH contribute to the range of AIDS education events in San Francisco. Health educators at district health centers, for example, provide general information on AIDS to church groups and alternative schools; public health nurses assigned to public schools give presentations about AIDS on an as-needed basis; and staff of the Bureau of Communicable Disease Control offer information and counseling at special events such as street fairs and community forums.

The privately supported Coalition of AIDS Healing Groups, with members including the AIDS Healing Alliance, Healing AIDS Newsletter, the Metaphysical Alliance, and the SF Macrobiotic Network, was organized in 1987 to expand awareness and knowledge in all communities of alternative and holistic healing practices and resources now available. The member groups assist groups and individuals in San Francisco and elsewhere in learning and applying a variety of alternative and healing programs and practices.

Although it does not fit neatly in any given educational category the national NAMES Project deserves mention as a forum for AIDS education. This quilt represents the deep sense of loss felt by those who love someone who has died of AIDS. In gathering people together to remember and remind others of the tragedy of this preventable disease, it is a powerful education tool. By displaying the quilt in cities and towns across America, it is the hope of the volunteers who have worked on the quilt that they are helping to combat ignorance and fear of AIDS and offer examples of compassion and love instead. Already the largest community arts project in the nation, the quilt will now become a powerful fundraising mechanism and educational tool in cities hardest hit by the epidemic.

#### Programs for youth

With funding provided by the Centers for Disease Control, DPH's Bureau of Family Health has cooperated with the San Francisco Unified School District in designing a comprehensive AIDS education program for middle and high school students. During FY 1986-87 an AIDS education curriculum was developed and teacher trainings were conducted for 120 middle and high school teachers. Curriculum guides were published for use in middle and high schools, and pilot tested on a total of approximately 650 students.



With funding again provided by CDC, teacher training and youth education will continue in 1987-88. One AIDS education lesson will be offered to all 24,000 students in San Francisco high schools and, for the first time, to all 14,000 middle school students. As the funding for this program per se is directed primarily toward training of teachers, it is discussed again with an accompanying budget in the chapter on Provider Education and Related Support.

DPH and SFUSD are also conducting educational outreach to several agencies in San Francisco that are identified as providing services to out-of-school youth. Through a community liaison, the particular training needs of each agency (e.g. Larkin Street Youth Center, Huckleberry House, Bayview-Hunter's Point Foundation) will be identified. Materials have been developed and half-day trainings are planned for the staff of approximately five youth service agencies during FY 1987-88. In turn it is expected that these and other agencies will distribute education materials and information to at least 2,000 out-of-school youth.

DPH has developed several innovative education programs for adolescents both in and out of school. During FY 1986-87 over 300 teenagers participated in a "Rap'n Down Contest" sponsored jointly by Community Public Health Services and the Bayview-Hunter's Point Foundation. This program, designed to create awareness in teens about AIDS, drugs, and sexually transmitted diseases, attempted to reach all adolescents but particularly those who were not attending school regularly. DPH's Community Public Health Services is planning to continue AIDS prevention outreach to out-of-school youth this year through health educators working at different community agencies providing health care and shelter for this population.

Another special effort, Community Public Health Services' Project Y.O.U.T.H.E., grew out of the Rap'n Down contest and is made up of the San Francisco Department of Public Health and youth service agency representatives from each district in San Francisco. Its objective is to educate young people 13 to 22 years old about the prevention of sexually transmitted diseases (STDs), drugs, and AIDS in San Francisco. Special emphasis is placed on 13-22 year-olds because survey data indicate that San Francisco teens are increasingly experimenting with and abusing drugs and alcohol. During FY 1987-88 Project Y.O.U.T.H.E. will sponsor a youth STDs, Drugs, and AIDS conference, "Youth Expo 88". The goal of the expo is to provide a long-term risk reduction educational program. This program expects to reach 1,000 adolescents.

The San Francisco Community College District, through its AIDS Education Office established in 1987, provides a variety of educational programs for the more than 50,000 students enrolled at the City College campus and seven satellite centers. Of the total enrollment, 79% are individuals from multi-ethnic backgrounds. The AIDS Education Office serves as a resource center for the District and provides classroom instruction, periodic workshops and seminars, and counseling and referrals for people concerned about AIDS. The District expects to reach approximately 6,000 students with AIDS education through classroom contacts in 1987-88.

San Francisco State University also has an active on-campus AIDS education program that is coordinated by a steering committee with faculty and staff representation from all schools of the University. This committee has been in existence for three years and, with the cooperation of a cadre of volunteers and the health educator of the student health service, hosts educational events throughout the school year. Efforts include periodic seminars, participation in national events such as AIDS Awareness Month, programs at residence halls, workshops for University employees such as the accounting department, inservice trainings for faculty, etc.

In addition there is an ongoing effort to bring AIDS into the curricula in all schools of the University. AIDS information and materials are made available in the Student Union, Library, and Student Health Center, specially designed inserts are periodically included in the campus paper, etc. There are approximately 26,000 students (comprised of about 50% racial and ethnic minorities) currently enrolled at the University with approximately 3,000 faculty and staff on campus. In 1986-87 5,400 individuals were reached through these educational efforts and it is anticipated that the program will expand its outreach during 1987-88.

The University of San Francisco, with a student population of 5,500, offers an array of AIDS prevention education services for its students and faculty. Through a campus AIDS committee (also in existence for three years), a survey of students, faculty, and staff was conducted in 1987 to evaluate AIDS knowledge. Based on the results of the survey, a brochure has been developed addressing the most common concerns and providing referral information. In addition the committee sponsors periodic seminars and workshops, educational events in the residence halls, and staff inservice days. Faculty are encouraged to incorporate AIDS into their classroom presentations.

Each school within the University of California at San Francisco conducts AIDS education for its graduate students. These efforts are discussed in the chapter on Provider Education.

## 6. Interactive Peer Groups

The Stop AIDS Project is an interpersonal communications campaign, underwritten by DPH's AIDS Office from January 1985 through June 1987, which sought to organize a community-at-risk (primarily self-identified gay and bisexual men) in San Francisco to achieve the goal of ending transmission of the AIDS virus. The major strategy of the campaign was to shift prevailing community norms about sexual behavior, to make "safe sex" and the social interactions which support safe sex the norm. The Project's main focus was not the individual but the group. It was viewed as a movement for social change with major health-promotion goals.

Street intercepts, door-to-door canvassing, and outreach to strategically placed opinion leaders were used to attract participants to



volunteer-facilitated small group meetings of 10-15 per single-session group. Participants were encouraged and empowered to communicate with their sex partners and friends about the campaign to end transmission of the AIDS virus. Stop AIDS meetings were held nearly every day of the week, including weekends, in the homes of volunteer hosts throughout the city.

The Stop AIDS Project was designed to provide a particular kind of educational "push" at a specific point in the history of the gay community's response to the epidemic. The designers of the program and DPH staff agreed that the need for such a program in San Francisco was largely met by June 1987. By that date, approximately 8,000 San Franciscans had participated in a Stop AIDS group. Although no longer in operation, it is important that the Stop AIDS Project's contribution to the overall AIDS education effort in San Francisco be recognized and appreciated. It remains a significant part of the overall fabric of that effort and its positive impact continues to be evident in 1987-88.

The UCSF/AIDS Health Project and PMHS/Operation Concern work together in providing one-time individual mental health consultations and closed, eight-week group support services. The target population for the services is people who are apprehensive about their prospects of becoming infected by HIV or of developing symptoms of AIDS if already infected. They want to identify and find support for new behaviors likely to reduce their risk. Additionally, the project offers both drop-in and closed groups specifically for people with ARC in an attempt to help these individuals deal with their illness and reduce behaviors that may put others or themselves at greater risk. The majority of clients served in this program to date have been gay-identified males. Project staff estimate that in 1987-88 over half will report testing positive for HIV antibody. Groups for special populations (e.g. members of racial and ethnic minority groups and women) are also organized on request; women who have felt at risk have been seen predominantly for health consultations only. Taken together, 4,000 San Franciscans are expected to participate in individual assessments and group sessions in 1987-88.

Also under contract with DPH's AIDS Office, the Latino AIDS Project of the Instituto Familiar de la Raza has committed itself to small-group educational programs for 250 intravenous drug users, 250 self-identified gay and bisexual men, and 250 high risk youth in 1987-88. Likewise the Multicultural Alliance for the Prevention of AIDS at Bayview-Hunter's Point Foundation has committed itself to small-group educational programs for 325 intravenous drug users, 300 self-identified gay and bisexual men, and 325 female heterosexual partners of high risk men. In each case, the recruitment activities and group interactions will be tailored to the audiences targeted, but for each group the interaction is expected to span more than a single group session. Although some of these efforts are specifically related to substance abuse, they are included in this chapter because their funding comes under an "information and education" label at the California Department of Health Services rather than "AIDS and substance abuse".

The Women's AIDS Network (WAN), a volunteer coalition of health professionals and community service providers, acts as an advocacy and



resource group for people with concerns about women and AIDS. With a membership of approximately 250, WAN provides sponsorship and speakers for conferences and workshops and expects to respond to over 400 requests for information from individuals and organizations in San Francisco during FY 1987-88.

Supported with funds directly from the State Department of Health Services, the California Prostitutes' Education Project (CAL-PEP) provides street outreach, weekly support groups, and monthly workshops to men and women in the sex industry. This organization provides prostitutes with AIDS prevention education, including practical safe-sex information.

To varying degrees, all of DPH's AIDS service contractors provide opportunities for meaningful volunteer participation. These include opportunities for self-actualization in the fight against AIDS which go beyond discussion of personal concerns and behavior changes. They have an important role to play in reinforcing, through peer support, attitude and behavior changes which are important to preventing the transmission of HIV or the development of clinical AIDS in those already infected.

## 7. Individual Health Education and Counseling

### General

The Department of Public Health provides an array of personalized AIDS education and counseling, much of which is not identified or budgeted as AIDS-specific. Physicians and nurses at district health centers, San Francisco General Hospital, and SFGH satellite clinics provide patient education and counseling as appropriate. Similarly, public health nurses, whose caseloads include many clients in need of AIDS prevention and education, offer direct patient education and counseling.

Disease control investigators at San Francisco City Clinic and in the Bureau of Communicable Disease Control also offer one-on-one AIDS education and counseling to high risk patients and their partners.

San Francisco's guidelines for the control of perinatally transmitted HIV infection call for AIDS education and counseling for patients of family planning, prenatal, and perinatal clinics. In 1987-88 DPH's Bureau of Family Health received a grant from the Federal Bureau of Health Care Delivery and Assistance to develop a provider education program in these settings to support implementation of the guidelines. The program is described in more detail in the chapter on Provider Education and Staff Support. Each year the Bureau of Family Health's own family planning and perinatal clinics see approximately 8,000 and 1,500 women respectively. Up to 30% of these women are believed to be at risk for AIDS.

Hemophiliacs and their families receive AIDS education and counseling from a Hemophiliac Team that works out of the Social Work Department of UCSF. The team, comprised of physicians, nurses, and social workers, follows 300

patients, the majority of whom are from San Francisco. Of these it is estimated that 80% have already been infected with HIV through blood products used before HIV antibody testing of such products became the standard of practice. To date, approximately 2% have actually developed clinical symptoms of AIDS or ARC. The team is supported in part with funding from the National Hemophiliac Foundation.

Approximately 85% of the 52,000 individuals who go through the county jails are considered to be at risk for HIV infection based on intake interviews that assess risk behaviors. DPH's Forensics AIDS Project coordinates AIDS education for jail inmates, and every person entering the forensic system is given information about AIDS either in print or verbally. The Forensics AIDS Project also conducts crisis intervention and short-term counseling for inmates who are HIV positive or have AIDS or ARC. The Project staff works with clients and jail physicians to write letters to the Court in an effort to obtain compassionate releases from custody for AIDS patients when appropriate.

The Forensics AIDS Project also provides informational materials and individual health education for clients seen in Sexual Trauma Services, The Center for Special Problems, Youth Guidance Center, and the Child Abuse and Sexual Assault Services. It is anticipated that approximately 550 individuals will receive information about AIDS through this program during FY 1987-88.

Epidemiologic research studies conducted by DPH, UCSF, and the University of California at Berkeley with cohorts of San Francisco residents provide a significant amount of individualized health education and counseling. These projects are described in more detail in the chapter on Epidemiology, Surveillance, and Related Research.

#### HIV antibody testing and counseling

The San Francisco Department of Public Health has offered HIV antibody testing at anonymous test sites (ATS) since July 1, 1985. The service was initially developed under a cooperative agreement with CDC to give people in high-prevalence populations an alternative to blood banks and plasma centers for HIV antibody testing. Since its inception, it has been promoted as a prevention education and counseling program which uses test results as catalysts for stimulating or reinforcing new patterns of low risk behavior.

In May 1986 the initial one-time funding from CDC ran out, and DPH concluded negotiations with the California Department of Health Services (DHS) to underwrite the services. The core program is mandated by State law, and the California Department of Health Services (DHS) provides reimbursement sufficient only to support on-site pre-test education, blood drawing, the necessary laboratory functions, and a brief post-test one-on-one result reporting and education session (which would average 30 minutes per positive and 3 minutes per negative, if only DHS funding were available).



DPH was able to direct other CDC funding (funding for health education and AIDS risk reduction in general rather than specifically for anonymous antibody testing) to support outreach education in the community (to expand awareness of the test and the advantages/disadvantages of being tested) and to extend the post-test counseling to an average of 40 minutes per positive (approximately 25% of the total) and 25 minutes per negative. The CDC funding was also used to train collateral service providers, health care staff, and mental health support service, to which people who have been tested are referred.

By May 1986 antibody testing and counseling services had been consolidated at a single location (SFDPH's Health Center #1) near the geographic heart of the city, in the Castro. Testing was and continues to be offered at this site five days a week. In response to requests that such testing be made more accessible, the program was expanded to four additional sites in September 1987, each operating one day a week, in the Mission, Western Addition, Southeast, and South of Market areas of the city. A fifth site is expected to be opened in the Tenderloin during the fourth quarter of 1987-88.

In San Francisco, anonymous HIV antibody testing is not done in the context of a more general medical examination, so it does not constitute screening in the usual sense. Because no personal identifying information is collected about clients, there are no opportunities for staff-initiated follow-up built into the program. The occasion of the test does, however, provide a unique opportunity to inform and motivate individuals who are obviously concerned about their health and usually willing to take a serious look at behaviors that put them at risk of becoming infected or, if infected, behaviors that may accelerate the clinical development of the disease.

The basic safeguards of anonymous testing are: (a) no personal identifying information on program participants is sought or recorded, and (b) staff of the testing program have no job-related responsibilities which are likely to put them in contact with those tested outside the ATS program. The purpose of (b) is to provide reasonable assurances that staff members will not be able to identify a person tested because of knowledge gained from job-related interactions.

Access to identification numbers, demographic data, information about tests conducted, and test results is limited to those authorized with access codes. Hard copies of identification numbers and summary reports are made at the time of reporting results, but these reports, with individual numbers matched to specific results, are secured or destroyed at the end of the session.

It is estimated that 15,000 clients will be tested and counseled at these sites in 1987-88, and will bring the cumulative total since July 1985 to 40,000. Of these, approximately 70% (28,000) are unduplicated. By June 1988, the program's monthly capacity is expected to be 1,350.



An indication of the success of San Francisco's expanded outreach effort and the reputation for "extra care" generated by the additional post-test counseling time can be found in data reported by the California Department of Health Services on visits to HIV antibody testing programs through December 1987. Comparing the number of tests done in San Francisco per 1,000 population to other areas of California suggests that San Francisco's program is seen as accessible to a much broader spectrum of the community than lower-profile programs in other parts of the state.

The anonymous testing program as currently designed has functioned efficiently and has been well received by the community as a whole. However, providers have often expressed concern that the test site at Health Center #1 and the satellite sites do not make the program accessible to some individuals at particularly high risk. The satellite sites make the program more accessible geographically, but education and blood drawing are still available by appointment only. The need to wait for appointments for blood drawing as well as test results can be frustrating to some and keeps away people who otherwise might be willing to participate in and benefit from the education and counseling associated with the testing program. Clients of sexually transmitted disease (STD) clinics, substance abuse treatment programs, and family planning, prenatal, and perinatal clinics are often thought to be in this category. Making HIV antibody testing more timely for these high risk individuals seemed an appropriate prevention strategy, as long as procedures are developed and maintained which adequately protect the identity of persons tested.

In 1987-88, therefore, CDC funding was applied for and received to specifically provide antibody testing and related counseling and support services at San Francisco's sexually transmitted disease clinic, City Clinic. The program is different from other city-managed antibody testing and education services in that patients can receive pre-test education and counseling and have their blood drawn during the time that the STD clinic is open and providing routine STD services. However, the staff providing these services do not otherwise work with patients in the clinic. All the other procedures associated with ensuring anonymity at test sites are followed here as well. The volume of patients passing through City Clinic is expected to make the assignment of staff exclusively to testing and related education and counseling cost effective.

A third effort related to antibody testing is also scheduled to begin in 1987-88: seroprevalence surveys at various clinic sites, which include provisions for the informed consent of those being tested and for related education and counseling. Since the focus is on research and the numbers to be tested relatively small, this program is described in detail in the chapter on Surveillance, Epidemiology, and Related Research.

The microbiology laboratory will analyze blood samples for HIV antibody for physicians in private practice who offer testing to their patients. Over 500 tests are expected to be done through this program during FY 1987-88.

D. FACTORS INFLUENCING THE DEVELOPMENT OF EDUCATION PROGRAMS

General pressures

1. The size and complexity of the epidemic and its impact on individuals, institutions, and the public psyche are expanding dramatically. Even when general education efforts have worked reasonably well, the growing pressure of circumstances encourages demagoguery and hysteria. General education needs to be provided on an ongoing basis, even in a community such as San Francisco, where overall community response has been very constructive.
2. Advocacy groups have emerged representing communities and settings that (a) recognize the threat of AIDS and the fact that it can be avoided by behavior changes and (b) are anxious to ensure that education and prevention support services are in place to make a significant dent in high risk behaviors in their communities and constituents. These groups include racial and ethnic minority interests, women's interests, youth-serving providers, and substance abuse education and treatment settings.

Serologic studies and other clinical indicators

3. Serologic studies of heterosexual IV drug users in treatment programs indicate that seroconversion among non-gay IV drug users has remained constant at approximately 3%, and by extension it would seem that education and prevention support services to this population and its distinct subgroups have shown some impact. Expansion of prevention and intervention services is essential, however. If one bases projections on the generally accepted estimate of 10,000 heterosexual IV drug users in San Francisco (both in and out of treatment) and current seroprevalence at 17%, this suggests that as many as 250 San Franciscans in this risk group may become infected in the next year if prevention education and intervention efforts are not more successful.

Seroconversion among heterosexual IV drug users is higher among non-whites than whites, indicating that education efforts to racial and ethnic minority groups in particular need to be expanded. In addition, substance abuse professionals identify many different subcultures within the substance-using community, necessitating the design of diverse prevention strategies to reach the community at all levels.

4. Population-based serologic studies of self-identified gay/bisexual men in San Francisco indicate that 50% of the community has already been infected with HIV. The annual seroconversion rate is less than 4%. This relatively low seroconversion rate in a community where



the "pool" of infected individuals is already so large suggests that the overall prevention education effort in this community has had an extremely positive impact.

While the seroconversion rate among gay/bisexual men has dropped dramatically, however, the population base against which it is applied is relatively large (42,500-69,000). Using the annual seroconversion rate of 4% suggests that between 850 and 1,350 gay and bisexual men in San Francisco may become infected in the next year if prevention education and intervention efforts are not more successful.

5. There has been a significant drop in the rectal gonorrhea rate reported at the City's STD clinic between 1981 and 1986. The number of gonorrhea cases has plummeted from a high of approximately 1,200 per quarter in 1981 to an average of 50 cases per quarter in 1987. This drop probably reflects changes in sexual practices within the San Francisco gay community. It appears that these changes began to take place within a relatively short time after the epidemic was first reported. This count of cases/quarter represents primarily new cases of rectal gonorrhea rather than repeat cases, indicating that there is a continuing need to reinforce safe-sex messages.
6. Other data from DPH's STD clinic indicate that STD rates among adolescents and young adults, particularly those from racial/ethnic minority communities, are still high.

#### Community surveys

7. Population-based surveys of knowledge and attitudes among gay and bisexual men also indicate that (a) the immigration to the community is high (an average of 8% per year over the past three years), (b) occasional lapses from safer sex practices (20% of individuals in one survey) are widespread, and (c) particular subgroups of the community (primarily those involved with substance abuse) have not responded satisfactorily to prevention education efforts.
8. A population-based survey of multiple/high-risk partner heterosexual adults indicates that risk group members are very active sexually, aware of the AIDS epidemic, and moderately informed about transmission, but that they have done little to accommodate behavior changes other than reduce somewhat (a) the number of partners they have and (b) their use of recreational drugs.
9. Population-based surveys specifically targeted to San Francisco's Black and Latino communities were completed in 1987. Data from these surveys should provide direction for the planning of educational strategies and an indirect evaluation of existing efforts. Some initial, largely qualitative assessments of San



San Francisco's Asian communities were conducted in 1987. Tracking surveys in the Black and Latino communities are scheduled for 1988, as is a baseline survey of Asian communities. These studies should help keep prevention education efforts in these communities appropriately focused. Few data are available on AIDS knowledge, attitudes, and behaviors for Native Americans, which has implications for efforts in this community.

Political controversy over the content of materials

10. Federal (CDC) and State (DHS) funding offices are particularly concerned that educational materials be "inoffensive" to the community at large. Since sexual behavior and substance abuse information is a significant factor in AIDS education materials, it can be difficult to meet Federal and State requirements and still provide messages that will effectively reach groups targeted. CDC has dealt with the issue by requiring the appointment of a local panel to review CDC-funded materials. DHS policy calls for review of all materials by DHS staff in Sacramento and prohibits the use of "slang". In one of the more interesting paradoxes of AIDS contracting, DHS has prohibited the distribution of "Can We Talk?" because it includes slang. This is a brochure which San Francisco's CDC-endorsed review panel singled out as one of the "best" they had seen, precisely because it used terminology to which the audience targeted was likely to respond.
11. Legislation was recently introduced at the Federal level by Senator Jesse Helms and others that would allow Federal funding of AIDS education materials only if the messages are not sexually explicit and only if they do not in any way suggest that homosexual activity of any sort is condoned. Such conditionals significantly restrict the ability of local efforts to design materials that are appropriate for educating and supporting constructive behavior change among gay and bisexual men.
12. In sharp contrast to the bureaucratic caution and political reaction reflected in these policies and legislative action, the recently released report on AIDS of the National Academy of Sciences' Institute of Medicine calls for educational programs that are "willing to use whatever vernacular is required for the message to be understood". The U.S. Surgeon General has also taken the position that "we can no longer afford to sidestep frank, open discussion about sexual practices--homosexual and heterosexual".

Other legislative mandates

13. The San Francisco Board of Supervisors has passed an ordinance requiring DPH to provide AIDS education for all employees of San Francisco City and County. This mandate was not accompanied by funding for the organization and implementation of the program or for the development of materials. Meeting the mandate without additional resources will seriously compromise access of other groups to such education.

## Other demographic issues

14. While the number of diagnosed cases in the adolescent population (13-19 years of age) remains low, the 20-24 year-old case rate in combination with 13-19 year-old cases provide a more accurate reflection of infection during adolescence, given the long incubation period. Of the 77 AIDS cases reported among these age groups in San Francisco as of September 1, 1987, 73 (95%) are gay or bisexual males, some of whom (29%) also indicated a history of IV drug use. One reported exposure through heterosexual contact.
15. While the number of documented AIDS cases among Asians/Pacific Islanders in San Francisco remains small, the fact that 43% of these (32 out of 75) have been among gay/bisexual Filipino men will focus special attention on this community.
16. While there are few data on HIV infection in people who use drugs other than intravenously, the disinhibition resulting from their substance use contributes to high risk behaviors. Treatment programs report an increase in the use of cocaine, both intravenously and in other forms, by heterosexuals, which has implications for education strategies as well.
17. Education efforts must not only take into account cultural and linguistic concerns but also consider the literacy levels of target populations. Literacy includes not only an academic reading level capability but also the manner in which different cultures use written language.

## Shifts in focus

18. As access to and utilization of anonymous HIV antibody testing programs increases, the number of individuals who know their antibody status will similarly increase. It is expected that there will be a corresponding increase in demand for education services which focus on dealing constructively with infection and inhibiting in whatever ways possible the development of clinical AIDS. Programs will need to be designed using the same approaches as prevention education to provide reliable information about social, psychological, and medical/treatment options available to those who test positive and are asymptomatic.

## E. POLICY REAFFIRMATION

1. The focal point of coordination of AIDS education (both public education and prevention support) in San Francisco should be the San Francisco Department of Public Health. DPH will seek the cooperation of the media, schools, physicians, dentists, other health professionals, community organizations, and individuals in developing and implementing effective education/information programs in combination with programs designed to support behaviors that do not put a person at risk of HIV infection.



2. The design and content of AIDS education and intervention efforts should be based on epidemiologic, behavioral, and social science research as well as careful assessments of targeted audiences' understanding of AIDS and its transmission, and of the obstacles which prevent adoption or maintenance of behaviors that do not put the person at risk of HIV infection.
3. DPH recognizes the importance of the evaluation of educational interventions and will support constructive ongoing evaluation when it can be regarded as cost-effective.
4. Educational materials should utilize language and visuals which the audience(s) targeted are most likely to understand and to which they will respond. Judgments about the propriety of materials produced and distributed with public funds should be made by local public health authorities and local review panels and should be based on careful assessments of the needs of local audiences.
5. The organizational bases from which AIDS education efforts in San Francisco are launched should be diversified. There should be a wide range of community settings and community-based organizations whose goal is to educate the general and at-risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with groups not yet well addressed by established programs (i.e. programs targeted to hard-to-reach gay men, substance abusers, racial and ethnic minority groups, out-of-school youth, street youth, and heterosexuals with multiple or at-risk partners).
6. DPH will encourage both traditional and nontraditional educational interventions in its commitment to the prevention of HIV transmission and AIDS.
7. Anonymous antibody testing should be available to anyone 14 years of age or older in the community who wishes to know his/her antibody status and is willing to participate in a pre- and post-test education and counseling program.
8. Confidential antibody testing should be promoted as a health education tool only if and when there is substantial community sentiment that procedures have been developed which adequately protect individuals participating in the program and the records of their test results. With increasing numbers of private test sites which use varying procedures for testing and for education/counseling, closer scrutiny must be made of the quality of these services.





#### IV. CONCERNS OF GAY AND BISEXUAL MEN

##### A. GOALS

Currently homosexual and bisexual men account for 96.4% of all the AIDS cases reported in San Francisco since 1981. Of the cases reported in 1987 alone, 95.8% were from this risk group. Men who have sex with other men also account for the vast majority of cases categorized under other demographic labels: 90.0% of those with a history of IV drug use, 87.1% of those in ethnic and racial minority groups, and 94.8% of the cases in which transmission probably occurred while the individual was an adolescent. Epidemiologists predict that HIV infection and AIDS cases will increase among intravenous drug users who are not gay men and among those who are at risk because of heterosexual activity, and that this increase is likely to be disproportionate to the increase for gay men. However, the same data indicate that the preponderance of HIV transmission and of new cases of clinical AIDS in San Francisco will continue to occur among men who have sex with other men for many years to come.

Achieving DPH's general goal of providing appropriate and timely education, health care, and other support services for people affected by HIV requires that all services must account for the manner in which they address the specific concerns of gay and bisexual men. With very few exceptions, most of their work will entail addressing these concerns.

##### B. BACKGROUND INFORMATION

The epidemiology of AIDS in San Francisco has differed from that in other high prevalence regions of the United States since the beginning of the epidemic. While 71.3% of cumulative AIDS cases reported nationally at the end of 1987 have been gay and bisexual men, 96.4% of the cases in San Francisco have been in this group. Further comparison of cumulative national statistics and local numbers makes it clear that the patterns of the epidemic vary dramatically from one area of the country to another. In some areas, heterosexual IV drug users, women who have been infected through sexual transmission, and children who have been infected perinatally are a much bigger part of the statistical picture than in San Francisco. Although examination of the national pattern gives us a clear indication of what could happen in San Francisco if the IV drug use problem were left unaddressed, the fact remains that AIDS in San Francisco predominantly involves gay and bisexual men.

Although seroconversion in gay and bisexual men is currently estimated at less than 4% in this population, this could still represent up to 1,350 new infections in the next year alone. It is projected that gay and bisexual men will represent 89% of cumulative AIDS cases in the city in 1992-93 (about 15,681 cumulative cases) and that between 2,107 and 5,708 individuals from this population will be alive and requiring AIDS-specific health care and support services that year.

## C. CURRENT SERVICES

Many of the AIDS services now in place (including education, clinical care, and psycho-social support services) evolved through the extraordinary efforts and advocacy by San Francisco's gay community. Currently, however, only a limited number of services are now designated specifically for gay or bisexual men, in the manner that AIDS services are designated as being specifically for women, children, or particular racial and ethnic minority groups. Notwithstanding the absence of a gay-specific designation, the vast majority of services---epidemiology, research, public education, provider education, primary care, hospital care, chronic care and support, mental health, and substance abuse---must ultimately deal with the gay-identified concerns of gay and bisexual men in San Francisco, if they are to contribute to meeting the goals described in this report.

Listed below are highlights drawn from other chapters of this report regarding services and activities which are labeled gay-specific.

- \* Between 1978 and 1980, the San Francisco Department of Public Health and the Centers for Disease Control recruited a cohort of 6,709 homosexual and bisexual men from San Francisco City Clinic, for studies of the incidence, prevalence, and prevention of Hepatitis B. Since 1983 DPH and CDC have conducted epidemiologic, clinical, and laboratory follow-up studies of this cohort to determine the incidence, prevalence, and natural history of human immunodeficiency virus (HIV).
- \* The AIDS Office collaborates with two additional cohort studies which are separately evaluating the prevalence of HIV infection in gay and bisexual men. One is a population-based study of single men (conducted by the University of California at Berkeley) monitoring HIV infection rates, assessing risk factors associated with transmission, and documenting the natural history of HIV disease. The other is a prospective study conducted by the University of California at San Francisco and San Francisco General Hospital that addresses similar issues.
- \* In the past four years, the San Francisco AIDS Foundation has commissioned four telephone surveys of gay and bisexual men to evaluate AIDS knowledge and attitudes, perception of risk, and level of risk behaviors. These surveys, conducted by Research and Decisions working in cooperation with Communications Technologies, have played a key role in designing educational campaigns that are most effective and appropriate for this community.
- \* Media advertising, pamphlets, videos, and collateral materials have been developed with prevention education messages that are specifically targeted to gay and bisexual men. The San Francisco



AIDS Foundation has designed advertisements for inclusion in gay-identified newspapers and magazines that address particular concerns of this community. Written materials (pamphlets, posters, resource guides, etc.) have been produced that address gay and bisexual men in particular.

- \* The San Francisco AIDS Foundation produces educational events with the intent to focus on the needs and concerns of specified communities. Approximately 30% of the events scheduled for 1987-88 will be targeted to gay and bisexual men. During FY 1987-88 SFAF held a one day conference for health educators and care providers on the current impact of AIDS on gay men in San Francisco.
- \* The Stop AIDS Project is an interpersonal communications campaign, underwritten by DPH's AIDS Office from January 1985 to June 1987, which sought to organize a community-at-risk---primarily self-identified gay and bisexual men in San Francisco---to achieve the goal of ending transmission of the AIDS virus. The major strategy of the campaign was to shift prevailing community norms about sexual behavior to make "safe-sex" and the social interactions which support safe sex the norm.
- \* The UCSF/AIDS Health Project and PMHS/Operation Concern work together in providing one-time individual mental health consultations and closed, eight-week group support services. The target population for the services is people who are apprehensive about their prospects of becoming infected by HIV or of developing symptoms of AIDS if already infected. The program also offers drop-in and closed support groups for people with ARC. There are groups which are specific to other populations (e.g. for women, for heterosexual men), which make many of the other groups gay-identified by default.
- \* In San Francisco two community organizations provide legal education on AIDS-related issues and free or reduced-cost legal services to persons with AIDS/ARC and their significant others: the Bay Area Lawyers for Individual Freedom (BALIF) and National Gay Rights Advocates (NGRA). Their education efforts focus on wills, testing, confidentiality, employment, insurance, and housing discrimination. NGRA is also active in promoting legislative and administrative policy initiatives to protect and better serve people with HIV-related concerns. Both organizations are gay-identified, although their services vis-a-vis AIDS are not limited to the gay community.
- \* The outpatient mental health clinic at District Health Center #1, located in the Castro, is integrally linked to screening and primary care of those in the neighborhood who are at risk for or diagnosed with AIDS/ARC. The mental health program is managed by gay-identified Operation Concern with support from CMHS. Operation

Concern reports that 30% of its clients are diagnosed with AIDS/ARC and that most of the remaining 70% are dealing with AIDS issues of sero-status, risk reduction, and coping with lovers, friends, and relatives with AIDS.

- \* 18th Street Services is an outpatient substance abuse counseling center for gay men in San Francisco which provides: (a) comprehensive education to all clients about their risk for AIDS and what they can do about it; (b) street-based education and outreach on AIDS and substance abuse to out-of-treatment adults and adolescents in the Tenderloin and Polk Gulch neighborhoods; and (c) substance abuse treatment for men who are diagnosed with AIDS or ARC or who are HIV antibody positive.
- \* PMHS' Operation Concern/Operation Recovery provides individual and group counseling to gay IV stimulant users who are diagnosed with AIDS/ARC or who test antibody positive. Their partners and significant others are also encouraged to participate in counseling as co-dependents, to assist in providing a support system for clients' recovery from IV stimulant substance abuse and adoption of safe sexual practices.
- \* The Latino AIDS Project of the Instituto Familiar de la Raza and the Multicultural Alliance for the Prevention of AIDS at Bayview-Hunter's Point Foundation have each developed a small-group educational program for gay-identified men in San Francisco's Latino and Black communities respectively.

#### D. FACTORS INFLUENCING AIDS SERVICES TO GAY AND BISEXUAL MEN

All of the factors listed in the remaining sections of this document will influence the development of programs and provision of services to gay and bisexual men. The factors listed below may particularly impact the design and implementation of these services:

1. There have been only intermittent efforts on the part of State and Federal offices to reserve specific levels of State or Federal funding for education or health care services for gay and bisexual men, the population group most affected by the epidemic in the United States. This posture reinforces the perception that the government is not concerned about the needs of the gay community.
2. Educational interventions must take into account that there are men who have sex with other men but do not identify themselves as being part of the gay community. Programs targeted to gay-identified individuals may miss this segment of the population, even though many of the behaviors and prevention issues are the same.



3. Legislation was recently introduced at the Federal level by Senator Jesse Helms and others that would allow Federal funding of AIDS education materials only if the messages are not sexually explicit and only if they do not in any way suggest that homosexual activity of any sort is condoned. Such conditionals significantly restrict the ability of local efforts to design materials that are appropriate for educating and supporting constructive behavior change among gay and bisexual men.
4. As therapeutic interventions for HIV-positive but asymptomatic individuals become more promising, gay and bisexual men in San Francisco---half of whom are believed to be HIV-positive---will be particularly anxious to secure easy access to such interventions, even at experimental stages of development.
5. In October 1987, the San Francisco AIDS Foundation sponsored a symposium on AIDS service delivery needs among gay men in San Francisco projected for 1988-1993. The report of these proceedings, which is to be published in the near future, will undoubtedly help to shape plans for services to this population group.

#### E. POLICY REAFFIRMATION

1. DPH should maintain its commitment to involving leaders from the gay community in program planning and policy setting. Although gay and bisexual men have been active as advocates and service providers in combating the AIDS epidemic from its outset, their influence and contributions to meeting the needs of the epidemic should not be taken for granted.
2. DPH should ensure the development of prevention education programs and intervention strategies in San Francisco which will meet the unique needs of gay and bisexual men in a timely fashion.
3. The design and content of AIDS education and intervention efforts among gay and bisexual groups should be shaped by information from epidemiologic research as well as careful assessments of (a) what targeted audiences already understand about AIDS and its transmission and (b) what stands in the way of their adopting or maintaining new behaviors.
4. Particular attention needs to be paid to AIDS education and prevention programs which will communicate effectively with the gay community. Individuals with cultural ties to targeted communities should be involved in the design of programs and research.



5. AIDS provider education must directly address attitudes that may distort the way in which information about AIDS is received by professionals who participate in training. Of particular concern where AIDS is an issue are attitudes about homosexual lifestyles.
6. DPH should ensure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture, and language should be evident in all service settings.
7. DPH should make every effort to ensure that staff in contract services and DPH settings in which services are planned or provided are culturally sensitive. In this context, one's identity as a gay person is the equivalent of one's racial or ethnic identity. Staffing patterns should reflect the populations targeted and served.
8. DPH should ensure that each AIDS service contractor includes in its annual program proposal a plan for addressing the special needs of the members of gay and bisexual groups as they relate to the services concerned.
9. DPH should ensure that gay and bisexual men participate in the Department's periodic monitoring of contract services.
10. DPH reaffirms its commitment to the enforcement of the City's AIDS antidiscrimination policy.

## V. CONCERNS OF RACIAL AND ETHNIC MINORITY GROUPS

### A. GOALS

In the United States, there are disproportionate numbers of AIDS cases among racial and ethnic minority groups. Although rates among these groups in San Francisco are lower, the numbers of reported cases have increased, and serologic studies in San Francisco suggest that the rate of seroconversion in racial and ethnic minority communities, particularly among substance abusers, is rising. The picture of what has happened in other communities, most notably on the East Coast, is a stark reminder of what could happen here if adequate measures are not taken to prevent further spread of HIV within these communities. There is a critical need for effective prevention programs with which members of these minority groups in San Francisco can identify and to which they can respond.

Achieving DPH's general goal of providing high-quality health care and other support services for people infected by HIV requires services which are culturally specific and linguistically appropriate for racial and ethnic minority groups.

### B. BACKGROUND INFORMATION

The racial and ethnic breakdown of total cases has indicated a trend of increasing numbers of members of racial and ethnic minority groups being diagnosed with AIDS each year in San Francisco, as shown below:

		<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>
White	Total	493	709	1028	1029
	%	89.0	84.7	84.7	80.1
Black	Total	23	47	80	103
	%	4.2	5.6	6.6	8.0
Latino	Total	34	67	84	116
	%	6.1	8.0	6.9	9.0
Asian-Pacific Islander	Total	4	14	19	36
	%	0.7	1.7	1.6	2.8
Native American	Total	-0-	-0-	3	1
	%			0.2	0.1

## AIDS in San Francisco 1987-88

There has been a fourfold increase in the number of new AIDS cases among nonwhites, from 61 cases in 1984 to 256 cases in 1987, compared to a twofold increase among whites. As has been the situation with cases among whites, in each minority community the majority of cases are men who have sex with other men: 80.0% of the Black cases, 93.6% of the Latino cases, and 88.0% of the Asian and Pacific Islander cases.

These counts of reported cases should be kept in mind, but the important numbers are those which indicate seroconversion. Since clinical AIDS usually takes a very long time to manifest itself (often in excess of five years from the time of infection), one- and two-year projections for reported cases are not a particularly graphic indicator of the challenge presented to education and prevention programs. In the absence of extensive data about seroconversion in San Francisco outside of San Francisco's gay and bisexual male community, we need to look at national patterns for some indication of what could occur.

Nationally, the statistics are quite different from the above San Francisco data. The table below reflects figures provided by the U.S. Public Health Service Centers for Disease Control on February 8, 1988:

Racial/Ethnic Group	Cases	Percent
White	31,742	61%
Black	12,974	25%
Latino	7,052	13%
Other	481	1%

From this table, it is clear that nationally there is a disproportionate number of people from racial and ethnic minority groups with AIDS: 39% of the AIDS population in the adult and adolescent group and 77% of the children with AIDS are from racial and ethnic minority communities. These disproportionate numbers have not been seen in San Francisco, as indicated in the first table. Therefore, San Francisco seems to have a unique opportunity to demonstrate that education and prevention programs, which are far less costly than treatment programs, can be effective in addressing the threat of AIDS among racial and ethnic minority groups.

### C. CURRENT SERVICES

Many of the programs described in the following pages interact regularly with racial and ethnic minority people but do not routinely document these as distinct services. Services targeted to gay and bisexual men, for example, often include members of racial and ethnic minority groups. AIDS education for youth in San Francisco schools, for employee groups, for patients of prenatal and perinatal clinics, and for substance abusers are additional examples of circumstances under which these groups are reached but not documented separately. Some services, therefore, are not described in this chapter because they are not specific to racial and ethnic minority groups, although they do reach people from these groups.



Listed below are highlights drawn from other chapters of this report regarding services which address the concerns specific to communities identified by race or ethnicity:

- \* By the end of 1986-87, baseline surveys of San Francisco's Black and Latino communities had been conducted to assess AIDS awareness, identify the prevalence of risk behaviors, measure the impact of the AIDS epidemic on sexual behaviors and lifestyles, and provide a baseline measurement of sexual and substance-using practices so that change over time can be measured. Tracking surveys in these communities are scheduled for the end of 1987-88.
- \* By the end of 1986-87, a planning process for conducting such surveys in San Francisco's Asian and Pacific Islander communities was completed. Grant funding has been secured for conducting baseline surveys in the highest risk communities in 1987-88.
- \* UCSF's Center for AIDS Prevention Studies works in collaboration with the Bayview-Hunter's Point Foundation and DPH on research which studies the impact of AIDS prevention efforts on minority communities. Their work has been expanded in 1987-88.
- \* Prevention education programs specifically targeted to Blacks, Latinos, and Asians are currently operated by community-based organizations identified with each of these population groups. Each program promotes print and electronic media coverage of issues related to the epidemic in their community, undertakes outreach activities, and offers a variety of forums and small-group interactions to encourage awareness and support behavior change. Videos for the Black and Latino communities have been designed to promote general population awareness of AIDS and each community's risk of infection.
- \* A prevention education program specifically targeted to the Native American community, which currently operates without direct funding from the AIDS Office, will be expanded with AIDS Office support by the end of 1987-88.
- \* The San Francisco AIDS Foundation, working in cooperation with the Red Cross and the Latino AIDS Project, has expanded the Spanish-language, bi-cultural services of their AIDS Hotline to 70 hours per week. Staff training for community-based organizations identified with other ethnic groups is being developed to ensure that callers needing telephone information and referral in other languages can be accommodated.
- \* Education and counseling associated with anonymous HIV antibody testing has been expanded considerably in 1987-88, and specific efforts have been made to make the program more accessible to

racial and ethnic minority communities. A multi-lingual and multi-cultural "rotating team" now offers education, testing, and counseling at five sites in neighborhoods with high concentrations of racial/ethnic minorities. Printed materials and videos are being developed for specific communities to support this effort.

- \* Overall, it is estimated that over 44% of funds budgeted for AIDS education, provider education, and AIDS services related to substance abuse in San Francisco now impact racial and ethnic minority communities directly.
- \* The continuum of provider education programs now includes an agency which provides consultation and training for AIDS service providers in San Francisco regarding cross-cultural issues related to serving racial and ethnic minority populations.
- \* The 1987-88 budget for San Francisco General Hospital includes funding to support the expansion of primary care clinics that will function as satellites of the AIDS Outpatient Clinic (Ward 86) at SFGH. At least one of these will be in a predominantly Black neighborhood. SFGH has also identified a physician to work specifically with primary care providers in racial/ethnic minority communities to facilitate their access to the expertise and support regarding AIDS care available at SFGH.
- \* The Client Services Department of the San Francisco AIDS Foundation has undertaken to outstation social workers in the offices of community agencies identified with racial/ethnic minority groups when there is sufficient demand and when such an arrangement makes their services more accessible to persons with AIDS/ARC. One of their client advocates is now stationed at the Latino AIDS Project for part of each week.
- \* Where data about patient/client ethnicity are available, figures from DPH-affiliated health care and related support services indicate that the proportion of individuals with AIDS/ARC from racial/ethnic minority communities using such services is equal to or greater than the proportion of AIDS/ARC cases in these communities.
- \* Substance abuse services identified with racial and ethnic minority communities have been provided with AIDS-specific funds to support the expansion of detoxification and treatment slots as well as prevention education for their constituents.

**D. FACTORS INFLUENCING AIDS EDUCATION AND SERVICES TO RACIAL AND ETHNIC MINORITY GROUPS**

All of the factors listed in the remaining sections of this document will influence the development of programs and provision of services to these target populations. The pivotal factors, however, are that leaders in each



community (medical and scientific professionals as well as service and advocacy leaders) have (a) come to appreciate the threat of AIDS and the fact that it can be avoided by behavior change, (b) perceived that the necessary education and prevention support services can significantly reduce high risk behaviors in their communities, and (c) begun to participate actively in the design and implementation of research and prevention programs in their own communities.

#### **E. POLICY REAFFIRMATION**

1. DPH will develop and implement, with minority community organizations, prevention education programs, intervention strategies, and treatment programs in San Francisco which will meet the unique needs of racial and ethnic minority groups at risk for AIDS.
2. The design and content of AIDS education and intervention efforts among racial and ethnic minority groups should be shaped by information from epidemiologic, behavioral, and social sciences research, the experience of community leaders and the media, and careful assessments of what targeted audiences already understand about AIDS and its transmission and of what stands in the way of their adopting or maintaining new behaviors that do not put them at risk for HIV infection.
3. The organizational bases from which AIDS education efforts in San Francisco are launched should be diversified. There should be a wide range of community settings and community-based organizations that educate the general and at-risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with people from racial and ethnic minority groups. Individuals with cultural ties to target communities should be involved in the design of programs and research.
4. AIDS provider education must directly address attitudes that may distort the way in which information about AIDS is received by professionals who participate in training. Of particular concern where AIDS is an issue are attitudes about racial and ethnic minority groups.
5. DPH should ensure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture, and language should be evident in all service settings.
6. DPH should make every effort to ensure that staff in contract services and DPH settings in which services are planned or provided are culturally sensitive and, where monolingual clients are



involved, language specific. Staffing patterns should reflect the populations targeted and served.

7. DPH should ensure that each AIDS service contractor includes in its annual program proposal a plan for addressing the special needs of the members of racial and ethnic minority groups as they relate to the services concerned.
8. DPH should ensure that racial and ethnic minority groups participate in the Department's periodic monitoring of contract services.
9. DPH reaffirms its commitment to the enforcement of the City's AIDS antidiscrimination policy.

VI. CONCERNS OF WOMEN

## A. GOALS

Women comprise a small proportion of the AIDS cases reported to date in San Francisco with almost half of them (46.2%) in women of racial and ethnic minority groups. Nationally, the proportion of AIDS cases among women is much higher than in San Francisco, and the vast majority (71.9%) are women from racial and ethnic minority groups. The small number of reported AIDS cases in women often gives an impression that this population is not at high risk of HIV infection. Such data cloud the potential that many women can become infected as a result of their high risk behaviors. Needle sharing by IV drug users plays a large role in the transmission of HIV to women both nationally and in San Francisco. The majority of women are infected by sharing needles themselves or through sexual contact with an infected IV drug user. HIV infection in a woman threatens not only her own life but that of her sexual partners and unborn children as well.

Public health concerns require that a high priority be placed on AIDS prevention education and services for women. There is a need for comprehensive services including AIDS education, HIV testing and counseling, substance abuse treatment, family planning, general health care, and social services that are culturally appropriate and tailored to the special needs of women.

## B. BACKGROUND INFORMATION

The reported AIDS cases among women in San Francisco are juxtaposed with the national figures in the following tables. They include the numbers of AIDS cases in women, their proportion of the total AIDS cases, and their breakdown by ethnic origin and route of transmission. The cases represented are those recorded by the San Francisco Department of Public Health AIDS Office and the U.S. Public Health Service Centers for Disease Control.

[National statistics reported as of February 1, 1988. San Francisco statistics reported as of January 31, 1988.]

Table 1: Cumulative Adult AIDS Cases

	<u>Nationally</u>		<u>San Francisco</u>	
	<u>Cases</u>	<u>Percent</u>	<u>Cases</u>	<u>Percent</u>
Adult males	47,676	92.6%	4,325	99.2%
Adult females	3,811	7.4%	33	0.8%

Table 2: Adult Female AIDS Cases by Racial Ethnic Minority Group

	<u>Nationally</u>		<u>San Francisco</u>	
	<u>Cases</u>	<u>Percent</u>	<u>Cases</u>	<u>Percent</u>
White	1,119	29.4%	18	54.6%
Black	1,999	52.5%	10	30.3%
Latino	659	17.3%	1	3.0%
Asian/PI	21	0.5%	4	12.1%
Other	13	0.3%	-	-
TOTAL	3,811	100.0%	33	100.0%

Table 3: Adult Female AIDS Cases by Transmission Category

	<u>Nationally</u>		<u>San Francisco</u>	
	<u>Cases</u>	<u>Percent</u>	<u>Cases</u>	<u>Percent</u>
Intravenous (IV) drug user	1,925	50.5%	15	45.5%
Heterosexual contact	1,117	29.3%	8	24.2%
Transfusion Recipient	415	10.9%	9	27.3%
Other	354	9.3%	1	3.0%
TOTAL	3,811	100.0%	33	100.0%

Of the total adult female cases reported by the end of January 1987 in San Francisco, 15 (45.5%) are themselves intravenous drug users, 8 (24.2%) are the partners of men at risk, and 9 (27.3%) have been identified as transfusion recipients.

These counts of reported cases should be kept in mind, but the important numbers are those which indicate seroconversion. Since clinical AIDS usually takes a very long time to manifest itself (often in excess of five years from the time of infection), accounts or projections for reported cases are not a particularly graphic indicator of the challenge presented to education and prevention programs.



The juxtaposition of data on AIDS among women in San Francisco with the national figures shown above supports the argument that we have an opportunity no longer available to many urban centers on the East Coast to prevent the spread of AIDS among women.

### C. CURRENT SERVICES FOR WOMEN

Some of the programs described in the following pages provide services to women but do not routinely document these as distinct services to women. Women's concerns are addressed to some extent under a variety of labels: services to "heterosexuals", "substance users", "racial and ethnic minority groups", "youth", "employee groups", for example. Listed below are highlights drawn from other chapters of this report regarding services which address women as a discrete target population. It identifies programs that are involved in HIV-related research, prevention education, and services for women in San Francisco:

- \* UCSF and SFGH coordinate three separate studies evaluating HIV infection in women and assessing the behaviors that put them at risk. Project A.W.A.R.E. in particular provides HIV testing, counseling, and follow-up of women at high risk for HIV infection. In addition, the Western Consortium for Public Health is examining the risk factors associated with heterosexual transmission of HIV.
- \* In 1986 the San Francisco AIDS Foundation commissioned a baseline survey of heterosexuals with high risk or multiple partners to assess AIDS awareness, identify the prevalence of risk behaviors, and measure the impact of the epidemic on their sexual behaviors. Forty-two percent of those who qualified and participated in the survey were women. A tracking survey of this population group is scheduled for 1988.
- \* In 1987 the San Francisco AIDS Foundation reestablished the position of "women's specialist" within its client services division and in 1988 the Foundation approved the establishment of a separate Women's Program to identify needs and existing services for women and their families, as well as provide resource development, advocacy, and community consultation for Foundation staff and community agencies. Currently there are two ongoing support and education groups for women with AIDS and ARC at the Foundation.
- \* The San Francisco AIDS Foundation has also committed itself in 1987-88 to a media campaign targeted to sexually active heterosexuals, the development of new brochures addressing women and pregnancy and women and condoms, workshops for women at health clubs, and a campaign (ads, posters, and workshops) targeting female and male sex industry workers.

- \* The Women's AIDS Network (WAN), a volunteer coalition of health professionals and community service providers, acts as an advocacy and resource group for people with concerns about women and AIDS. WAN receives staff support from the San Francisco AIDS Foundation.
- \* The California Prostitute Education Project (CAL-PEP) provides outreach and education to female prostitutes for HIV risk reduction. Efforts include street outreach as well as weekly workshops focusing on safer sex and safer needle use.
- \* The Multicultural Alliance for the Prevention of AIDS at the Bayview-Hunter's Point Foundation has committed itself to small-group educational programs for female sexual partners of high risk men in 1987-88.
- \* UCSF's AIDS Health Project provides one-time individual mental health consultations for women. A psychiatric social worker is outstationed part-time at the Lyon-Martin Women's Health Care Center. Women seen there for general medical services are referred to the AHP project worker for AIDS prevention and risk-reduction counseling.
- \* DPH's Bureau of Family Health, supported by a grant from the U.S. Public Health Service, will be developing a resource manual and providing AIDS training and technical assistance for perinatal health care providers in San Francisco city-funded facilities. This training will include information on perinatal HIV infection, risk assessment, guidelines for testing and counseling, and management of health care and social services.
- \* Youth Environment Studies' program includes four community outreach workers who focus exclusively on female sexual partners (who do not use IV drugs themselves) of IV drug users.
- \* DPH's Bureau of Family Health offers AIDS education and counseling for patients of family planning, prenatal, and perinatal clinics. SFGH's Women's Health Center also provides AIDS education and counseling to its patients.
- \* Planned Parenthood of San Francisco provides AIDS education, anonymous or confidential HIV testing, counseling, and referrals for women with concerns about AIDS.
- \* The Family Addiction Center for Education and Treatment (FACET) provides perinatal education and services for pregnant drug users. Since many clients are at high risk of HIV infection, the program offers AIDS risk reduction education, HIV testing and counseling, and referrals in association with UCSF and A.W.A.R.E.



- \* Where data about patient/client gender are available, figures from DPH-affiliated health care and related support services indicate that the proportion of women with AIDS/ARC using such services is consistent with the proportion of the total number of women with AIDS/ARC in the community.
- \* In August 1987, the Director of Health convened an Interdivisional Task Force on Women's Health Issues in order to assess the status of women's health and services in San Francisco. Working in cooperation with the Women's Health Committee, the Task Force developed a report which was presented to the Health Commission in January 1988. The report indicated that HIV-related health care and social services are, in fact, being utilized by women with AIDS and ARC. It was noted, however, that there are a number of gaps in services for women at risk of HIV infection. Specifically, there is a need for more substance abuse treatment, particularly in residential centers where women could live with their children.

#### D. FACTORS INFLUENCING AIDS EDUCATION AND SERVICES TO WOMEN

All of the factors listed in the remaining sections of this document will influence the development of programs and provision of services to women. Women in leadership positions have come to appreciate the threat of AIDS and perceived that education and prevention support services can significantly reduce high risk behaviors among women. This fact has been pivotal in developing the women-specific services.

#### E. POLICY REAFFIRMATION

1. DPH, in cooperation with women's groups, will ensure the development and implementation, in a timely fashion, of prevention education programs, intervention strategies, and treatment programs in San Francisco which will meet the unique needs of women at risk for AIDS.
2. The design and content of AIDS education and intervention efforts among women should be shaped by information from epidemiologic, behavioral, and social sciences research, and careful assessments of what targeted audiences already understand about AIDS and its transmission and of what stands in the way of their adopting or maintaining new behaviors. Women should be involved in the planning and design of programs and research that address women-specific issues.
3. There should be a wide range of community settings and community-based organizations that educate the general and at-risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with women.



4. AIDS provider education must directly address providers' attitudes that may distort the way in which they receive information delivered in trainings and the way in which they impart information to their patients/clients. Of particular concern where AIDS is an issue are attitudes about women.
5. DPH should ensure that services are provided in a manner which makes them as accessible and acceptable as possible to the patients being served. Sensitivity to gender-related differences in lifestyle, culture, and language should be incorporated in all service settings.
6. DPH should make every effort to ensure that staff in contract services and DPH settings in which services are planned or provided are sensitive to women. Staffing patterns should reflect the populations targeted and served.
7. DPH should ensure that each AIDS service contractor includes in its annual program proposal a plan for addressing the special needs of women as they relate to the services concerned.
8. DPH should ensure that women participate in the Department's periodic monitoring of contract services.
9. DPH should ensure that programs providing services and housing to women with AIDS include provisions for child care services which can help to maintain the family unit.
10. DPH should ensure that women are represented on program planning staff and staff of service agencies contracting with DPH. All staff must be trained to deal with the special needs of women. Family issues may be of particular concern for women. Sensitive issues regarding substance abuse, sexuality, family planning, pregnancy, childcare, housing, and legal matters must be addressed in an open, non-coercive manner.

VII. CONCERNS OF CHILDREN AND ADOLESCENTS

## A. GOALS

Adolescents and children comprise a small proportion of the AIDS cases reported to date. There is evidence, however, that high risk behaviors among adolescents have been increasing, especially among racial and ethnic minorities. Studies showing high rates of adolescent sexual activity, sexually transmitted diseases, and unintended pregnancy indicate that adolescents place themselves at high risk of HIV infection through their behaviors. The risk of perinatal transmission is related directly to the incidence of infection among women of childbearing age and among their sexual partners.

It is the goal of AIDS services in San Francisco to halt the transmission of HIV to children and adolescents and to provide medically appropriate health care and related support services for those infected and those who have developed clinical manifestations of AIDS or ARC. Although the number of AIDS cases reported to date in children and adolescents is small in San Francisco, the importance of developing policies and programs to meet their specific needs cannot be underrated. It is important to implement AIDS prevention education and services for childbearing women, children, and adolescents that are culturally appropriate and, when targeted to children themselves, tailored to their developmental needs.

## B. BACKGROUND INFORMATION

The table below presents statistics for AIDS cases among children (ages 0-12 years), adolescents (ages 13-19 years), and young adults (age 20-24 years) that have been reported nationally and in San Francisco. They show the numbers of AIDS cases in young people and their proportion of the total AIDS cases.

[National statistics reported as of February 1, 1988. San Francisco statistics reported as of January 31, 1988.]

Table 1: Cumulative AIDS Cases in Youth

	<u>National</u>		<u>San Francisco</u>	
	<u>Cases</u>	<u>% of total</u>	<u>Cases</u>	<u>% of total</u>
<u>0 - 12 years</u>	797	1.5%	14	0.3%
<u>13 - 19 years</u>	217	0.4%	5	0.1%
<u>20 - 24 years</u>	2336	4.5%	86	2.0%

Children under 12 years of age have become infected with HIV perinatally (i.e. from an infected mother) and from transfusion of blood products. Among the 13 AIDS cases in children reported in San Francisco as of January 31, 1988, 7 were children of high risk parents and 6 were children who acquired the infection from transfusion. Since screening of the blood supply began in 1985, perinatal transmission of the infection has accounted for nearly all of the new HIV infections in children. The vast majority of perinatal HIV infection has been associated with parental intravenous drug use.

Racial and ethnic minority children have been disproportionately affected by AIDS nationally. Across the United States there have been 797 cases of AIDS reported in children under 12 years of age as of February 1, 1988. Of those, 77% (611) were children born to a parent with or at risk of AIDS, 14% (112) were infected with HIV through transfusion, and 5% (44) had hemophilia/coagulation disorder. Of those children born to a parent with or at risk for AIDS, approximately 62% of them were Black, 22% were Latino, and 15% were white. In San Francisco, 7 of the cases in children in San Francisco have been born to a parent with or at risk for AIDS and 6 of these are Black or Latino. The 6 cases of AIDS in children have been attributed to a blood transfusion. Of all 13 cases in San Francisco, 7 are white, 3 Black, and 3 Latino.

Adolescents have acquired HIV infection through blood products, sexual contact, and IV needle use. While the number of diagnosed cases in the adolescent population (13-19 years of age) remains very low (5 cases, which account for 0.1% of the total cases reported in the city), the 20-24 year-old case rate in combination with 13-19 year-old cases provide a more accurate reflection of infection during adolescence, given the long incubation period. Of the 77 AIDS cases reported among these age groups in San Francisco as of September 1, 1987, 73 (95%) are gay or bisexual males, some of whom (29%) also reported a history of IV drug use. One reported exposure was through heterosexual contact.

### C. CURRENT SERVICES FOR CHILDREN AND ADOLESCENTS

Children are served by many of the programs that were previously discussed in the chapter on women, and education programs for adolescents, both in and out of school, are discussed in the chapter on public education. The following list identifies programs that are specifically involved in HIV-related research, prevention education and services for children and adolescents in San Francisco.

- \* UCSF Department of Pediatrics, UCSF Pediatric Hemophilia Center, and SFGH Children's Health Services provide comprehensive health care services for infants, children, and adolescents with HIV-related conditions. UCSF and SFGH are also conducting research studies including seroprevalence, natural history of HIV infection in women and children, and behavioral risk factor assessments among adolescents.



- \* The Family Addiction Center for Education and Treatment, FACET, a program of Bay Area Addiction Research and Treatment, BAART, provides perinatal education and services for pregnant drug users. The program also provides pediatric medical follow-up for infants born at risk for HIV infection as well as drug withdrawal.
- \* Several committees have been organized with representatives from the DPH and both local and regional agencies and providers to assess community needs, set priorities, develop policies, and establish guidelines around perinatal, pediatric, and adolescent AIDS issues. These committees include a Pediatric and Perinatal AIDS Task Force, a Foster Care and AIDS Task Force, an Adolescent AIDS Task Force, and a School AIDS Advisory Committee.
- \* Shanti Project has a support group for children who have a parent with AIDS.
- \* With funding provided by CDC, DPH's Bureau of Family Health has cooperated with the San Francisco Unified School District in designing a comprehensive AIDS education program for middle and high school students. All 24,000 students in San Francisco high schools and, for the first time, all 14,000 middle school students will receive one AIDS education lesson during the 1987-88 school year.
- \* During FY 1986-87, DPH and Bayview-Hunter's Point Foundation organized a "Rap'n Down" contest designed to create awareness in teens about AIDS, drugs, and sexually transmitted diseases. It was targeted specifically at students who do not attend school regularly. Out of this contest grew "Project Y.O.U.T.H.E.". The objective of this program is to educate young people ages 11-22 about the prevention of sexually transmitted diseases, teen pregnancy, self-esteem, domestic violence, drugs, and AIDS. A year-long program of health education activities in communities throughout the city will culminate in a two-day "Youth Expo 1989".
- \* DPH's AIDS Office and Bureau of Family Health, with the cooperation of the Multicultural Prevention Resource Center and Shanti Project and the support of community groups and the San Francisco Unified School District, are implementing an AIDS prevention education project for youth at risk, especially ethnic and racial minority youth in community and school settings. This project, known as "The Wedge", brings together a health professional, an AIDS educator, and a person with AIDS/ARC to present their unique perspectives on AIDS.
- \* Larkin Street Youth Center, Hospitality House, and Huckleberry House are drop-in centers and shelters for homeless, high risk youth. Health services provide general health care, AIDS

education, risk assessment and counseling, and medical referrals for all participants.

- \* DPH's Youth Guidance Center, San Francisco's detention and education facility for delinquent youth, provides general health care, AIDS education, risk assessment, and counseling for all incoming youth. This program is implemented in coordination with the DPH Jail Medical Services and the Forensics AIDS project.
- \* The Department of Social Services operates a special foster care program for infants of drug addicted mothers or others at extraordinarily high risk of HIV infection. This program, called "Baby Moms", provides very specific training for foster parents on the care of at-risk infants and offers them monthly support groups and 50 hours of respite care each month. As of December 1987, 14 high risk babies were placed in eight homes; three of them were HIV antibody positive.
- \* The Parent Support Group of the UCSF Intensive Care Nursery will hold two parent conferences during 1988 to provide information and emotional support for parents of children who received blood transfusions at UCSF between January 1978 and April 1985. Advertisement of these support groups has been mailed to 1,000 families.
- \* SFGH and UCSF coordinate three separate studies that evaluate HIV infection in women and assess the behaviors that put them at risk. Women participating in these studies receive counseling and as much social, emotional, and practical support as the researchers are able to provide. They often bring concerns about their children with them to the studies.

#### D. FACTORS INFLUENCING SERVICES TO CHILDREN AND ADOLESCENTS

All of the factors listed in the remaining sections of this document will influence the development of programs and provision of services to children and adolescents. A realization that children and youth require a unique and specially designed configuration of services will facilitate the expansion of the limited services currently available to them. For example, as the number of pediatric and adolescent AIDS cases increases, a comparable increase in pediatricians and other clinicians with the expertise to care for these patients will be needed. Research into appropriate pharmaceutical therapies for children and youth will need to be conducted and may impact the type of clinical services they require. Emotional support and counseling services for children and adolescents are different from those for adults. Special training will need to be provided for mental health professionals to become proficient at dealing with AIDS issues for children and young adults.



**E. POLICY REAFFIRMATION**

1. DPH should ensure the development of prevention education programs, intervention strategies, and treatment programs in San Francisco which will meet the unique needs of children and youth at risk for AIDS.
2. The design and content of AIDS education and intervention efforts among youth should be shaped by information from epidemiologic, behavioral, and social sciences research, and careful assessments of what targeted audiences already understand about AIDS and its transmission. Where appropriate it is important to include adolescents in the planning and implementation of programs and research that address issues specific to young people.
3. There should be a wide range of community settings and community-based organizations that educate the general and at-risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with women of childbearing age, children, and adolescents.
4. AIDS provider education must directly address issues regarding perinatal transmission as well as pediatric and adolescent HIV infection. All AIDS training, in particular sessions specific to providers that specialize in services to youth, should help providers develop skills that enable them to effectively approach adolescents with AIDS prevention education.
5. DPH should ensure that services are provided in a manner which makes them as accessible and acceptable as possible to the patients being served. Sensitivity to concerns of parents with children with AIDS and to adolescents should be incorporated in all service settings.
6. DPH should make every effort to ensure that staff in contract services and DPH settings in which services are planned or provided are sensitive to the needs of children and youth. Staffing patterns should reflect the populations targeted and served.
7. DPH should ensure that each AIDS service contractor includes in its annual program proposal a plan for addressing the special needs of children and youth as they relate to the services concerned.
8. DPH reaffirms its commitment to providing ongoing medical consultation to community agencies and organizations such as the San Francisco Unified School District and Department of Social Services, who provide medical and support services for children and youth with HIV infection.
9. DPH should ensure that programs providing services and housing to women with AIDS include provisions for child care services which can help to maintain the family unit.



10. DPH reaffirms its commitment to collaborate with the San Francisco Unified School District and community agencies to provide comprehensive AIDS education and prevention programs aimed at youth both in and out of school. These programs must be culturally sensitive, acknowledge the special concerns of gay youth, and address the range of issues particular to youth and AIDS.
11. DPH acknowledges that AIDS services for children must address the child's ability to comprehend information, his/her behavior, fears, and health care and social needs. Children should be provided with appropriate information and the opportunity to participate in decisions for health care and risk reduction.
12. DPH recognizes that HIV infection in infants and children is often associated with parental HIV infection, drug abuse, poverty, homelessness, family disruption, and other significant problems. These families need special support services including advocacy, drug treatment, financial assistance, respite care, and housing. For families that are unable to care for their children, foster care and adoption should be available.
13. DPH recognizes that youth who are disenfranchised from their families (e.g. runaways and delinquents) are at particularly high risk for HIV infection due to their drug and sexual behaviors. Many adolescents fail to comprehend their risk for HIV infection and fail to access AIDS prevention education and health care. Programs that serve adolescents must utilize comprehensive, age-appropriate strategies for outreach and education, health care, psychosocial support, drug treatment, and housing.

# VIII. PROVIDER EDUCATION AND STAFF SUPPORT

## A. GOALS

The programs which the Department of Public Health includes under the general heading of "Provider Education" serve two categories of providers:

- (1) those who routinely provide services to people who are sick or concerned about their health (health care professionals and hospital workers, mental health and substance abuse treatment professionals, health aides, emergency service workers, etc.); and
- (2) those who, because of their work, are uniquely placed to educate others about the problem, reduce hysteria, and promote risk reduction (teachers, the clergy, detention facility staff, etc.).

In the case of those who routinely provide services to people who are sick or concerned about their health, the goal of provider education is to help them understand and respond appropriately around issues of diagnosis, treatment, and infection control, patient/client rights, psychosocial pressures generated by the epidemic, risk reduction, and the availability of related support services. In the case of those in a position to serve as a vehicle for education, the issues are similar but the emphasis is more on risk reduction and the special psychosocial dynamics of the epidemic than on the technical aspects of diagnosis and treatment.

Provider education is particularly complicated when AIDS is at issue, because service providers sometimes bring bias to such training. The vast majority of those in San Francisco who have been infected with HIV and have developed AIDS or ARC are members of behavioral minorities (gay men and IV drug users). To some, their behaviors are at best difficult to understand, and at worst reprehensible. Because providers may not appreciate or tolerate the lifestyles of these two particular groups, they may bring ingrained biases and/or fear to any training session. People with AIDS/ARC and those at risk are frequently blamed for their circumstances. Insensitivity to the special concerns of racial and ethnic minority groups is often part of the bias as well. Provider education, therefore, must address these prejudices along with issues that are specific to HIV infection.

Programs which DPH includes under the general heading of "staff support" serve individuals who provide custodial and ancillary services in health care settings (e.g. clerical staff, housekeeping staff, maintenance staff, couriers, etc.). These are people who may or may not interact with patients but who are nonetheless directly affected by all of the issues related to patient care that are mentioned above. Education for these providers, as for others, must include dealing with personal fears regarding the possibility of becoming infected with HIV through the course of their work.

Education for AIDS service providers and support staff may be further complicated by the facts that HIV-related illnesses are extraordinarily complicated and the clinical presentations, diagnostic methods, and treatment of these illnesses are ever-changing. In addition, social issues related to AIDS---such as the lack of support systems for many patients or the problem of retaining insurance with an AIDS diagnosis---may significantly impact even the most noble patient care efforts.

Finally, working with people with HIV infection can generate great emotional strain on providers. Although extremely rare and under unusual circumstances, cases of HIV transmission to clinical staff caring for AIDS patients have been reported. However unlikely such transmission may be in statistical terms, all direct service providers must deal with repeated questions from friends and family, if not from themselves, about the extent of the risk associated with their work. In addition, the work often entails close contact with young individuals, most of whom are dying or facing the prospect of early death after a series of particularly debilitating illnesses. These circumstances call for an unusual degree of professional support for "processing" the anxiety, anger, and grief associated with their roles as service providers. The emotional pressure facing providers can also confound their ability to comprehend and respond constructively to information provided about AIDS and AIDS-related issues.

## B. ELEMENTS OF SERVICE

As has been the case with other service areas discussed in this report, the elements of provider education may be categorized in a variety of ways which result in groups that are neither mutually exclusive nor independent of one another. For the purposes of this chapter, the description of current AIDS-related provider education will be organized by the type of service or specialty of the group targeted. It is important to recognize that some of the providers may offer services in more than one arena and that they may regard a different taxonomy as more indicative of their emphasis and primary concerns.

- (1) Training and Support for Medical Professionals and Other Health Care Workers
- (2) Training and Support for Mental Health Professionals
- (3) Training and Support for Substance Abuse Professionals
- (4) Training and Support for Emergency Response Workers and Detention Facility Staff
- (5) Training for Teachers from Middle School to University Level
- (6) Other Provider Education



## C. CURRENT SERVICES

Professional associations and university-based training programs are expanding their role in educating their constituencies about AIDS. In addition there are periodic regional, national, and international conferences organized to inform and educate professional service providers about AIDS. Interest in AIDS is also increasingly reflected in professional journals and newsletters. Although San Francisco-based providers are frequently high-profile participants in these forums, their activities are not included in the service descriptions that follow. The programs identified below are those which specifically target San Francisco service providers for training and support.

## Training and Support for Medical Professionals and Other Health Care Workers

(1) Educational programs supported by San Francisco General Hospital and UCSF faculty based there

San Francisco General Hospital offers health professionals and support staff in San Francisco a variety of opportunities to benefit from the expertise that has been developed through its extensive experience caring for people with HIV infection. The list of educational activities is long and only those efforts that are offered on a regular basis are mentioned here.

## (a) Publications

San Francisco General Hospital (SFGH) publishes a quarterly newsletter, AIDSFile, specifically for physicians. Its articles focus on AIDS clinical care and research. This newsletter is distributed to physicians in the Bay Area and, on request, in other parts of the country. In addition, the SFGH staff regularly contribute clinical, research, and epidemiologic data to many different publications in an effort to offer the most current AIDS information to providers.

## (b) Community outreach

Through its AIDS Activities Division, SFGH coordinates several outreach efforts to community physicians. These efforts are designed to (1) provide clinicians with the most current information about AIDS so that they can deliver quality care to patients in their practices, (2) communicate with clinicians regarding the availability of experimental treatment protocols, and (3) encourage participation by community physicians in the development of new and more effective therapies for HIV infection and its complications.

SFGH hosts the County Community Consortium (CCC) monthly. The consortium is a group of clinicians working primarily in private practice with persons with HIV-related illnesses. Through the consortium they receive

regular updates on diagnosis and treatment and participate actively in clinical research by designing studies that involve their patients. Interest by the members of the CCC encouraged the coordinators to initiate, in addition to the Consortium meetings, a series of case presentation conferences or AIDS Clinical Grand Rounds at various hospitals in the San Francisco area which focus on patient management issues. It is expected that an average of 60 to 70 physicians will attend AIDS Clinical Grand Rounds each month during FY 1987-88.

In cooperation with UCSF, San Francisco General Hospital also sponsors a two- to three-week training for physicians from the United States, Europe, and Asia that offers material encompassing both the clinical and nonclinical aspects of AIDS (from direct patient care to an intensive overview of psychosocial, economic, administrative, and educational issues related to AIDS). This program, the AIDS Provider Education Experience (APEX), is the result of a generous private donation. APEX has trained 13 physicians in the last year and expects to train a similar number in FY 1987-88.

The medical staff on Ward 86 (the AIDS outpatient clinic) and Unit 5A (the AIDS-dedicated inpatient unit) frequently consult with other physicians in San Francisco and around the country regarding AIDS patient care. The AIDS Activities Division employs one physician who spends approximately two-thirds of her time acting as a liaison between SFGH and the community. She provides in-service training for the medical staff at SFGH satellite clinics and other community service agencies, facilitates communication with other divisions of the Department of Public Health, acts as a consultant to community providers interested in caring for AIDS patients, and provides referrals to SFGH when appropriate.

(c) In-house education, training, and support

As the AIDS epidemic has continued to grow, so have the issues of concern for health care workers and support staff. Coordinated and comprehensive education and training has become increasingly vital. Such efforts obviously include regular AIDS-specific clinical education for providers through "in-house" grand rounds, lectures, and seminars. They also include periodic trainings that focus on issues of immediate concern, such as infection control.

For example, as DPH has instituted infection control policies that require universal body-substance precautions, training related to the implementation of these procedures is a priority. Open forums have been held for service providers and support staff to discuss concerns related to infection control. A comprehensive, hospital-wide in-service training program on universal body-substance precautions is currently organized and is expected to reach most SFGH employees in FY 1987-88.

Providing information alone is not sufficient to alleviate the concerns that many health care workers, both professional and non-professional, may have about AIDS. Such concerns may be related to the potential for



occupational exposure to HIV, to the overwhelming pressures of caring for people with AIDS, etc. SFGH commits resources on a continuing basis to provide emotional and educational support for hospital staff.

(2) Other training provided by the University of California, San Francisco

With funding from the National Institute of Mental Health, UCSF has organized the AIDS Professional Education Project (APEP). This program sponsors a preclinical elective course for medical and nursing students on AIDS, coordinates the AIDS/ARC Update Conference mentioned later in this chapter, and organizes advisory committees to consult on the integration of AIDS material in curricula for medical and nursing students. In collaboration with the APEP program, UCSF faculty are actively involved in regular education efforts for professional and support staff on a variety of AIDS-related issues. These include "in-house" grand rounds that are specialty-specific, periodic in-service trainings for house staff and other UCSF hospital employees, faculty, and house staff support groups.

Dentists play a significant role in the AIDS epidemic. They provide routine dental care for people with HIV infection, diagnose oral, head, and neck manifestations of HIV infection; they may provide specialty care and/or appropriate referrals for people with AIDS; and they have the opportunity to conduct AIDS education.

The University of California at San Francisco, through its School of Dentistry, conducted a pilot education program of 100 dentists in San Francisco in 1986-87. This project was done as a research study. Fifty of the dentists received AIDS information through written materials and a "question and answer" consultation with an AIDS expert. The study group scored significantly higher on a test of AIDS knowledge, attitudes, and behavior than did the control group. Using the results of this study, UCSF is seeking funding to expand AIDS education for all dentists in San Francisco using a "train-the-trainers" model.

(3) Training provided by the California Nurses Association

In 1986-87, the California Department of Health Services (DHS) issued a contract to the California Nurses Association (CNA), working in cooperation with the San Francisco AIDS Foundation and AIDS Project Los Angeles and with special assistance from DPH's AIDS Office, to develop and pilot a state-wide program to train hospital- and agency-based trainers of hospital and home health agency staff. In planning for 1987-88, DHS announced that direct DHS funding for the state-wide program would be discontinued, although local adaptations of the program would be encouraged. DPH subsequently applied to DHS for funding to continue the program in San Francisco, which was granted. DHS later reestablished the state-wide program through another direct contract with CNA.

CNA's "Train the Trainer Program" consists of three basic components: (a) initial training for those educating professionals and support staff in their institution or agency, (b) follow-up education for those who have



completed the initial program, designed and implemented a training program at their home institution or agency, and (c) limited on-site consultations at institutions and agencies for program participants. By the end of 1987-88, approximately 120 trainers from San Francisco facilities will have completed the initial CNA training and 60 will have completed the follow-up training.

(4) Training and support provided by other community agencies

Shanti Project offers quarterly trainings for health care providers that address the emotional, social, and practical support issues confronting both people with AIDS and their care providers.

The Veterans Administration Medical Center offers a monthly two-hour community forum on AIDS that is open to staff and the general public. This forum typically addresses a range of topics from social issues and AIDS to detailed clinical case presentations. In addition, the VA offers regular clinical inservices for medical staff and workshops for ancillary staff on AIDS.

**Training and Support for Mental Health Professionals**

Since its inception in 1984, the UCSF AIDS Health Project (UCSF/AHP) has provided educational services to mental health professionals, making the skills and experiences of the project staff available to psychotherapists, social workers, and health educators at all levels of training and licensing. AHP also offers training about the psychosocial issues in AIDS to other health care providers. There are multiple and complex issues raised by this disease: most notably the need to discuss sexuality and sexual practices, issues of death and dying, the related issue of suicide, and the ethical issues raised in the care and treatment of persons with this potentially terminal illness. AHP also maintains an active link with Community Mental Health Services and other mental health agencies in the Bay Area.

Operation Concern, a gay-identified community mental health agency, cooperates with the UCSF/AIDS Health Project in the training of mental health professionals who see people with AIDS/ARC and/or their significant others.

Working in concert, these two providers organize and conduct workshops, forums, and smaller trainings for mental health professionals in both public and private settings. It is anticipated that 8,886 will receive AIDS-specific training in San Francisco in FY 1987-88. Some will be mental health providers working with HIV-related concerns; others will be health care providers working with psychosocial concerns of people with AIDS/ARC. The AHP has published a comprehensive resource guide for mental health professionals as well as a video that explores the professional and personal concerns of mental health practitioners working with AIDS patients.

Another AHP-sponsored service, which organizes therapists in private practice who are willing to donate time for work with persons with AIDS/ARC (described in detail in the chapter on mental health services), also schedules

a support group for participating therapists. This group offers an opportunity for these "volunteer" therapists to share their experiences with this population.

### **Training and Support for Substance Abuse Professionals**

The AIDS and Substance Abuse Education Program (ASAP) of the UCSF AIDS Health Project provides consultation and training on the intimate and complex interaction between AIDS and substance abuse. ASAP assists substance abuse agencies in dealing with AIDS and AIDS agencies in dealing with substance abuse. Services include formal training on such topics as substance abuse assessment, counseling strategies for substance abuse clients with AIDS concerns, and basic AIDS information. ASAP also provides consultation services that center upon treatment planning for individual clients and programmatic or agency needs concerning substance abuse and AIDS training. During the past year, all drug and alcoholism treatment programs in San Francisco have been contacted and have had in-service training or consultation for staff members. Periodic updates are provided for agencies on an as-needed basis.

Training programs are tailored to meet agency-specific needs. That is, particular attention is given to special issues of concern for agencies whose clients are predominantly from a racial or ethnic minority, which have specific cultural concerns (e.g. gay men), or which target a specific subpopulation of the community (e.g. women, youth, etc.).

DPH's Community Substance Abuse Services (CSAS) also contracts with the Bayview-Hunter's Point Foundation to develop and implement training for CSAS agencies that is specific to the concerns of their Black, Latino, and Asian clients at risk for AIDS. These information and education services will be directed towards the Board of Directors, key members, and staff of each agency and its contractors, and the community at large. In addition to six two-day trainings for substance abuse and mental health providers serving ethnic minority communities, a one-day conference will be sponsored in FY 1987-88 to provide information to substance abuse providers in the San Francisco area.

### **Training and Support for Emergency Response Workers and Detention Facility Staff**

The Forensics AIDS Project, a program of the Division of Forensic Services in the Department of Public Health, coordinates AIDS education for all emergency response workers and forensic staff in San Francisco. With funding from the State of California, this Project trains trainers in the police, fire, sheriff, and emergency medical services (paramedics) departments. The Forensics AIDS Project has supplemented existing materials and developed other materials to address concerns specific to the expertise of each department.



## **AIDS in San Francisco 1987-88**

It is anticipated that approximately 2,000 emergency response workers will participate in an AIDS education session by the end of FY 1987-88. This will include an initial training for every member of the police, fire, and paramedic forces and a retraining for all sheriff's department employees. It is hoped that this education will help to alleviate employees' fears regarding their own risk and enable them to provide the most appropriate service in circumstances where AIDS is an issue or concern.

The Forensics AIDS Project, with support from the Centers for Disease Control, assumes responsibility for the development of informational materials and the training of all forensic personnel, including staff of the jails, sexual trauma services, Youth Guidance Center (the juvenile detention center), and the Child Adolescent Sexual Abuse Resource Center. Materials that are developed address very specific topics at issue for these employees, such as rape and AIDS.

The trainings include an assessment of AIDS knowledge and concerns and a presentation of current information about AIDS. The prevention of HIV transmission and issues of special concern for those who are incarcerated are emphasized. Education for forensic staff also details issues of confidentiality of medical treatment and records, their legal obligations related to clients with HIV infection, and other worksite-specific concerns. It is anticipated that at least 250 forensic staff will be trained in FY 1987-88.

### **Training for Teachers from Middle School to University Level**

In 1986-87 the San Francisco Department of Public Health, in cooperation with the San Francisco Unified School District (SFUSD) and with financial assistance of the CDC, provided training for all family life education teachers in the 23 high schools in San Francisco. In addition, curriculum guides were published for use in middle and high schools, and pilot tested on a total of approximately 650 students.

During FY 1987-88, again with support from the Centers for Disease Control (this time direct to SFUSD), approximately 80 teachers will receive a three-day training on AIDS and the use of these curricula. Preference for registration for these trainings is given to special education and bilingual teachers, and the materials developed are being modified to address concerns these teachers may have for the particularly vulnerable student populations that they reach. Forty high school history teachers will receive a two-day training on incorporating AIDS into their lessons. In addition, a five-day regional teacher training program will be offered to seven select teams of 5-8 individuals representing different health and education disciplines primarily from jurisdictions other than San Francisco. All teams will participate in two days of the training. The other three days will focus on such specific issues as curriculum development, outreach and community organization, programs for out-of-school youth, etc.



DPH and SFUSD are also conducting educational outreach to several agencies in San Francisco that are identified as providing services to out-of-school youth. Through a community liaison, the particular training needs of each agency (e.g. Larkin Street Youth Center, Huckleberry House, Bayview-Hunter's Point Foundation) will be identified. Materials have been developed and half-day trainings are planned for the staff of approximately five youth service agencies during FY 1987-88. In turn it is expected that these and other agencies will distribute education materials and information to at least 2,000 out-of-school youth.

In addition to school education through the teacher training project described above, DPH is implementing a pilot AIDS prevention project utilizing a multi-step approach to disseminate factual, age-appropriate, and culturally sensitive AIDS prevention information to youth at risk. Youth of ethnic, racial, and sexual minorities in community and school settings are the focus of this program, which is termed the "Wedge".

The "Wedge" will use a team approach that brings together a medical professional, an AIDS educator, and a person with AIDS to present their unique perspectives on AIDS. Although the program is described in more detail in the chapter on education for the general public, one of its essential components is training for the members of the team. Each of the representative team members will receive two half-day trainings designed to help them present some aspect of the medical, emotional, or social aspects of AIDS to adolescents. It is anticipated that approximately 60 individuals will receive training under this program that will enable them to participate in the "Wedge" team education program.

The AIDS Education Office of the San Francisco Community College District provides AIDS information and education for faculty and staff throughout the District. In-services and seminars are offered to the 3,000 faculty, staff, governing board, and administrators. Established late in 1987, this office is in the process of designing a comprehensive resource and education program.

#### Other Provider Education

##### Publications

The publication of research findings in professional journals is an extraordinarily slow process. Often it takes six months or longer for "new" information to become available to health care professionals through this medium. A variety of newsletters and bulletins published locally provide professionals access to the most current information about AIDS and about services provided locally for people with AIDS-related concerns.

AIDSFile has already been mentioned in conjunction with support for medical professionals. In addition, DPH's Bureau of Communicable Disease Control publishes the monthly San Francisco Epidemiologic Bulletin. Its articles relate pertinent information, such as the change in the CDC AIDS case

definition, AIDS surveillance updates, etc. Policies developed at the local level are published in the Epidemiologic Bulletin and submitted to scientific journals. Examples of such policies include: Guidelines for the Control of HIV Infection in Adolescents, Education Guidelines for Children with HIV Infection, and Guidelines for the Control of Perinatally Transmitted HTLV-III-LAV Infection.

The UCSF AIDS Health Project also publishes a monthly newsletter, Focus: A Guide to AIDS Research, that highlights issues of concern to health care professionals and others working with AIDS. Focus places AIDS research data and medical reports in a context that is meaningful and useful to readers who want to stay current with AIDS information but who are not themselves researchers. Focus was established in 1985-86 with State funding administered by DPH; it is now supported entirely by subscription revenues.

#### Annual events

In San Francisco, UCSF's AIDS Professional Education Project (APEP), with the support of the Department of Public Health and community-based service providers, now sponsors the annual "AIDS/ARC Update". This two-day conference offers a smorgasbord of lectures, workshops, and information displays on a wide range of subjects, including basic medical and epidemiologic information, psychological issues, special concerns of groups at risk, and legal, social, political, and educational issues.

In November of 1987, DPH held a three-day national AIDS conference. This conference was cosponsored by several community-based organizations and targeted service agencies, clinicians, and local health departments in smaller communities across the United States. Although it was a program developed primarily in response to thousands of requests that San Francisco-based services receive each year for information about and insights into "the San Francisco model", approximately one half of this year's 1,500 registrations came from staff of San Francisco institutions, offices, and agencies. It is anticipated that this conference will be held annually.

UCSF and SFGH jointly sponsor semi-annual conferences specifically targeted for clinicians, that address current issues in the comprehensive management of AIDS patients. These conferences are designed to provide the most up-to-date research and experiential data for those involved in patient care. Each conference has a slightly different clinical care focus.

#### Other regularly scheduled activities

DPH's AIDS Office coordinates a monthly AIDS Grand Rounds targeted to community physicians, DPH health care professionals, and other community service providers. These Grand Rounds typically include an epidemiologic update of AIDS in San Francisco and then address a public health topic of general interest to participants. Examples include prevention of HIV transmission in adolescents to AIDS, AIDS and suicide, trends in HIV seroconversion in gay and bisexual men in San Francisco, etc.



DPH's Bureau of Health Promotion sponsors an annual two-day regional training for health educators, again providing the most current AIDS information and facilitating the development of innovative health education strategies.

DPH's AIDS Office recently issued a request for proposals for consultation and training for AIDS service providers in San Francisco regarding cross-cultural issues related to serving racial and ethnic minority populations. Polaris Research and Development was awarded the contract. Consultations and training are expected to begin by the spring of 1988.

Included in the AIDS Office's contract with Asian American Recovery Services are provisions for the Asian AIDS Project to develop education and training programs specifically designed to sensitize AIDS providers to the special concerns of their Asian clients and to inform Asian providers about AIDS. They expect to reach 270 providers in FY 1987-88.

#### D. FACTORS INFLUENCING PROVIDER EDUCATION DEVELOPMENT

##### Number and distribution of providers

1. As HIV-related cases become more numerous, and health care for AIDS and ARC becomes more decentralized, the number of professionals whose jobs involve them with the epidemic will expand. In other words, the number of people needing AIDS-specific provider education and support will expand. In particular, it will be necessary to expand outreach to providers who are bilingual and/or who serve racial and ethnic minority communities.
2. Decentralization or redistribution of inpatient and outpatient care will require hospitals and outpatient clinics to do more in-service education. In other words, the number of settings for which AIDS-specific provider education will have to be tailored will also increase. Training of care-givers about AIDS is not only labor intensive but may take longer than other routine orientations. This factor should be considered when planning for the implementation of provider education in a given setting.

##### Underserved provider groups

3. Most provider education efforts to date have focused on "professional" health and human services staff, i.e. job categories whose occupants usually have and often exercise access to opportunities for further training and development. Efforts to implement AIDS-specific training programs for non-professional or support staff (for example, hospital orderlies, nutritionists, technicians, ward clerks, and other clerical staff) have been



hampered by administrative and budgetary constraints. It therefore appears at times that the education needs of these providers have been ignored or unrecognized. Administrators will have to establish training for all staff members as a priority and provide release time as needed for such training.

4. Although AIDS-specific training programs exist in San Francisco for emergency response workers (such as police, fire, lifeguard, and ambulance employees), there is a need for further development.
5. Dentists and their associates seem critically underserved by AIDS-specific provider education programs. The California Dental Association currently has no organized AIDS education program and relies on the American Dental Association's AIDS position statement for policy direction. Efforts are currently in progress to initiate coordinated AIDS outreach. Similarly, provider education for such professionals as optometrists, acupuncturists, chiropractors, etc., is sparse, at best.
6. AIDS provider education must address directly prejudices that may distort the way in which information about AIDS is received by those participating in training. Of particular concern where AIDS is at issue are attitudes about homosexuality, racial and ethnic minority groups, women, people with substance abuse and mental health problems, and death and dying.

#### Emerging clinical concerns and practices

7. The epidemic continues to show new faces. Providers at all levels are presented with an overwhelming amount of new information on an ongoing basis. Constructive maintenance education will still involve considerable outreach and complexity. Education and training must continue to update existing and traditional disciplines but incorporate in their curricula information about alternative therapies, relevant legislation, etc.
8. Issues concerning infection control have become a major concern for health care workers in all settings. Administrators must place a high priority not only on the establishment of infection control policies and guidelines but also on the development of extensive staff training and support programs to ensure their effective implementation. Training for health care workers around emerging infection control policies, such as universal blood and body substance precautions, requires an understanding and commitment by administrators and department supervisors that the educational strategy used addresses both the factual and emotional components of the issue.

Universal body substance precautions (BSP) are a philosophically new approach to infection control which removes patient labels upon

which medical staff have typically depended. Training for staff must explain the procedures associated with this policy as well as help staff to understand that they are better protected without the traditional diagnostic labels.

At San Francisco General Hospital the very recent initial implementation of universal blood and body substance precautions is a hospital-wide effort. This effort has required involving staff from all departments and clinics in the planning process, providing training for supervisory staff in every department and clinic, organizing both staff education sessions and emotional support groups, and providing the necessary release time for staff to attend. Implementation of BSP requires that such training be institutionalized and also demands the purchase of necessary supplies and equipment.

One of the stresses for those with body fluid contacts associated with providing patient care is concern that infection may be transmitted to the care-giver. For HIV infection this is a very small but definite risk for those who suffer specific exposures such as deep needle-stick injuries. A well-planned system, which is sensitive to employee concerns about employer knowledge of sero-status, and which provides counseling and testing to exposed employees, is a necessary part of infection control and of dealing with provider stress.

9. Given greater diversity in provider settings and personnel, some agreement about standards of care and standards of education about care will have to be reached. West Bay Hospital Conference has collected information about standards of care and published a report.
10. Legislation regarding issues of confidentiality for people with HIV infection, mandatory HIV antibody testing in some settings, etc., is introduced with regularity in the State Legislature. Incorporation of changes in confidentiality laws, of the legal obligations of providers, and of the rights of clients must be incorporated in training for all health care staff.

#### Emerging social concerns

11. Increases in the numbers of AIDS-affected patients who are not gay-identified men (e.g. heterosexual IV drug users, their female sexual partners, children) will require continual reevaluation of service needs of AIDS/ARC patients.
12. New tactics of the peddlers of AIDS hysteria will have some impact on the attitudes of potential providers as well as on the funding available to support provider education.



Burnout and staff turnover

13. There is general acknowledgement among provider groups that the stresses associated with providing services to persons with, at risk for, or concerned about HIV-related illness are extraordinary. In relatively few instances, however, have significant efforts been undertaken to help providers address the issues of fear, anger, and grief in an ongoing way. We continue to rely on the exceptional commitment and willingness to extend oneself that is typically expected of dedicated staff in a crisis situation. At some point such expectations are likely to become untenable.
14. Given the prospect of staff turnover, new providers, and new responses to the epidemic, constructive provider education will continue to require several levels of training: a constant "introductory" level, an "update" level, etc.

Funding

15. State support of provider education has focused on the "train-the-trainers" approach and has tried to accomplish even this limited task in a one- or two-year effort. California DHS often assumes, usually incorrectly, that local resources are available to fund the ongoing work of trainers exposed to one-time State-subsidized training. Local resources are extremely limited.
16. Federal funding has been secured to support some training efforts (e.g. NIMH underwrites the UCSF AIDS Professional Education Program, and HRSA now underwrites the AIDS/Substance Abuse training provided by UCSF's AIDS Health Project, as well as the racial/ethnic minority training for which Polaris has contracted), but it is not clear whether sufficient Federal support will be forthcoming.
17. HRSA funding has been made available for a statewide Education and Training Center for physicians and dentists, but San Francisco providers are not yet included in the groups targeted by the Fresno-based program. This center (the Area Health Education Center or AHEC) has representation from San Francisco on its planning committee. Efforts need to be made to encourage the program to include San Francisco providers, especially dentists.

E. POLICY REAFFIRMATION

1. DPH will participate in the development of comprehensive and constructive AIDS education components in a broad spectrum of (a) professional degree training programs, (b) university-affiliated



continuing education and in-service training programs, (c) training opportunities organized by professional associations and labor organizations, and (d) in-house training offered by local service providers. Experienced providers based at DPH should cooperate by making their experience available to those who are planning and implementing such training.

2. DPH should assist as much as possible in training efforts that will ultimately enhance the capacity of private-sector providers to accommodate needs generated by the AIDS epidemic.
3. DPH recognizes that, to be constructive, AIDS provider education must directly address prejudices that may distort the way in which information about AIDS is received by those who participate in training. Of particular concern where AIDS is at issue are homophobic, racist, and sexist attitudes. In addition negative or misunderstood beliefs about people with substance abuse and mental health problems and individual providers' own difficulties dealing with death and dying can adversely affect their ability to care for people with AIDS.
4. DPH recognizes that AIDS provider education programs have a special responsibility to address concerns of stress and burnout among providers. Programs must be developed in all service areas that provide care for the care-givers. These programs are essential not only to reduce staff turnover resulting from burnout but in order to assure that the care being delivered to people with AIDS is of the highest possible quality.
5. DPH expects that service providers whose professional skills are enhanced by training provided through City-sponsored programs should be expected to help defray the cost of such training.
6. DPH should ensure that there continue to be forums for the presentation and discussion of ethical dilemmas presented in the course of patient care. These "ethics committees" should meet on a regular basis and should be available to all providers with moral and ethical concerns so that issues may be resolved in a proactive manner whenever possible.
7. DPH reaffirms its commitment to the enforcement of the City's AIDS antidiscrimination policy.



## IX. PRIMARY CARE AND SPECIALIZED OUTPATIENT CARE

### A. GOALS AND ACTIVITIES

The focus of San Francisco's care for persons with AIDS and other clinical manifestations of HIV infection has been on serving patients outside of inpatient acute care settings. The model calls for comprehensive outpatient services and an extensive network of complementary support programs. Its goal is to function as a coordinated whole that ensures optimal primary care for adults, children, and adolescents through services that are medically appropriate, psychosocially supportive, cost effective, and sensitive to cultural, linguistic, and sexual preference issues. It is a model which strives to engage family, friends, and community as fully as licensed health care providers in the process of caring for and supporting those who suffer from HIV illness.

Primary care is provided at established clinical sites and physicians' offices where persons with HIV-related illness typically make their first contact with the medical system and/or where they are able to return for routine medical care and health maintenance. This type of care includes screening, general medical care, referral for special treatment or diagnostic procedures, counseling, medication and other therapy, and follow-up. The clinic or doctor's office provides a center for continuity of care.

Many individuals who may not have access to these traditional care settings seek their primary care in emergency rooms, substance abuse treatment clinics, or other settings where services are immediately available. While the primary care provided at these sites may in some respects be similar to what is described above, it is difficult for clinicians to offer services that are continuous. Even when patients are given referrals for follow-up, they often do not return for subsequent care.

In San Francisco a number of clinical settings provide screening, information, and referral services for persons with HIV disease, but do not attempt to serve the expanded role of primary care provider for persons with AIDS or ARC. These services will also be discussed in this section.

The review of current services will cover outpatient settings that provide specialty care, support patients on experimental therapeutic protocols, or conduct special medical evaluations.

### B. CURRENT SERVICES

The discussion of current services is divided into four sections:

- (1) Services based at or whose budgets are administered by San Francisco General Hospital (SFGH) (with the exception of substance abuse services, which will be discussed in a subsequent chapter on that subject);



- (2) Services at other health centers administered or supported by the Department of Public Health;
- (3) Services at community-based clinics and community hospitals; and
- (4) Services of physicians in private practice.

#### SFGH Outpatient Services

The primary care and specialized outpatient care features of San Francisco's response to AIDS have at their hub a highly specialized AIDS outpatient clinic center at San Francisco General Hospital (SFGH), Ward 86. The overall purpose of this center is to concentrate the expertise of a wide variety of medical disciplines (e.g. oncology, infectious diseases, neurology, pathology, dermatology, oral medicine, ophthalmology, virology, epidemiology, gastroenterology, parasitology, immunology, and pulmonary medicine) to provide the care required by patients with HIV-associated diseases. The concentration minimizes the logistical complications of "moving" patients from one specialist to another and thus makes high-quality care more accessible to them. It also encourages a minimum number of admissions for inpatient care, and stays as short as possible for those admitted.

Ward 86 provides primary care to many people with AIDS and ARC in addition to providing specialized medical evaluations and therapeutic protocols for AIDS/ARC patients being followed by other primary care providers. It also serves as SFGH's outpatient center for oncology patients. At present, however, AIDS/ARC encounters at Ward 86 account for 84% of the total number of patients. Ward 86 offers:

- initial clinical evaluation and referral services for AIDS and ARC
- comprehensive medical care, including diagnosis, treatment, and follow-up care, to people with AIDS and ARC
- various outpatient procedures that might otherwise require a hospital admission, such as transfusions, hydration, and chemotherapy administration
- on-site phlebotomy
- active participation in AIDS-related clinical research
- access to comprehensive and coordinated psychosocial support services for people with AIDS and ARC.

To reinforce the involvement of physicians outside of Ward 86 in the evaluation and primary care of AIDS/ARC patients, Ward 86 staff offer clinicians opportunities to benefit from the expertise being developed at SFGH

regarding the diagnosis, treatment, and support of their patients. This role as a resource to the larger medical community is discussed more fully in the section of this document devoted to Provider Education. Physicians in private practice and from other government-funded clinics who participate in these training programs are often able to enroll their patients directly in clinical drug trials managed by SFGH and the University of California at San Francisco (UCSF). The success of this and other provider education efforts have ensured increased sophistication in the care of AIDS/ARC patients who are being followed in private practices and in other community clinics. It is now estimated that the majority of AIDS/ARC patients in San Francisco are evaluated and followed by primary care providers outside of Ward 86, most in private practice.

The data reflected in Table 1 clearly show that the role of Ward 86 in direct outpatient services has grown more slowly than the number of persons living with AIDS at any given time. This reinforces the perception that physicians in private practice and at other clinical settings are playing an expanding role in AIDS/ARC primary care. Table 1 illustrates the shifts that have occurred since 1983, when most AIDS/ARC patients in San Francisco seemed to be followed at San Francisco General Hospital.

Table 1: Changes in numbers of persons diagnosed with AIDS and living with AIDS compared to changes in numbers of patient encounters at Ward 86

	AVERAGE PER MONTH		
	<u>83-84</u>	<u>86-87</u>	<u>% CHANGE</u>
No. PWAs living in SF	261	1,247	378%
No. OP registrations at Ward 86 (AIDS/ARC)	538	1,294	141%
No. newly diagnosed PWAs in SF	32	106	231%
No. first-time registrants at Ward 86 (AIDS/ARC)	62	82	32%

It is not evident from data currently available precisely where the outpatient activity not accounted for at Ward 86 has shifted. The general impression left by the fact that community hospitals now account for 67% of the inpatient admissions for persons with AIDS/ARC in San Francisco is that community hospital clinics and physicians in private practice have played an important role in absorbing most of the shift.

HIV-related patient registrations at Ward 86 are expected to total 20,000 in FY 1987-88. In November 1987, 450 patients with clinically defined AIDS were being followed. Of the AIDS/ARC patients seen on Ward 86 in 1986-87, approximately 15% were from racial/ethnic minority groups and 5% were women. It is anticipated that these percentages will remain consistent during FY 1987-88.



There continues to be a three-week waiting period to get an initial appointment for evaluation on Ward 86. This would indicate that some individuals may be in need of the low-cost services at SFGH but not able to access them immediately because the AIDS Clinic is operating at capacity.

Compared to the level of activity at Ward 86, the impact of the epidemic on other primary care centers located at or overseen by SFGH has to date been relatively small. These other primary care services at SFGH are organized as ten outpatient clinic centers, seven of which are hospital-based and three of which are community-based satellite clinics. The hospital-based clinic centers are: the Adult Medical Center, Third and Fourth Floor Adult Surgical Centers, the Children's Health Center, the Women's Health Center, the Family Health Center, and the Dental Center (which also offers services at satellite centers). The three satellite clinic centers are the South of Market Health Center, the Potrero Hill Health Center, and the Southeast Health Center. Mission Neighborhood Health Center is another primary care referral site in the network of City services although it is not directly under the supervision of SFGH.

The hospital-based outpatient clinic centers provide a range of primary care services from screening to care that is specific to their specialties. All of these centers see patients with HIV infection, and they play an essential role in the system of care for these patients over time. The services provided by each center are indicated below.

1. The Adult Medical Center offers to adults a range of services, including an initial screening clinic, primary care clinics in which patients with chronic medical problems are followed regularly, and medical specialty clinics. Some of the specialty clinics are Chest, Diabetes, Endocrinology, Gastrointestinal, Hypertension, Physical Therapy, Infectious Disease, Renal, Rheumatology, Cardiac, Dermatology, and Occupational Health.
2. The Third Floor Adult Surgical Center offers general surgical and surgical specialty services. The specialty services include Vascular, Proctology, Plastic, and Trauma. The Third Floor Adult Surgical Center also offers general orthopedic services and orthopedic specialties, including Sport Medicine, Hand, Podiatry, Pediatric Orthopedic, and Spine. The Urology service also operates out of this clinic center.
3. The Fourth Floor Adult Surgical Center offers medical and surgical services through the Neurology and Neurosurgery clinics, the Otolaryngology clinic, the Optometry and the Ophthalmology clinics, and the Audiology service.
4. The Children's Health Center offers to patients, under 18 years of age, a range of services including emergency, general, and specialty services. The specialty clinics include Allergy, Dermatology, Cardiology, Hematology, Diabetes, and others. A



Teenage Family Planning Program offering medical services, pregnancy testing, birth control, and outreach services is available through this center. Services for sexually abused children and adolescents are available 24 hours a day through the Child and Adolescent Sexual Abuse Resource Center. San Francisco General is a facility with the professional expertise to care for children with HIV infection, but almost all children with AIDS or symptomatic HIV infection are participants in a study based at UCSF's Moffitt Hospital. Some of these children receive their primary care there but, as with adult primary care, the majority seek their care in the private sector. While many high risk and HIV-infected mothers may deliver babies at SFGH, few of these infants are actually cared for at SFGH because of the UCSF program at Moffitt.

5. The Women's Health Center offers several clinical services, including Gynecology, Obstetrics, Dysplasia, and Infertility. Extensive family planning services, including therapeutic abortions, tubal ligations, vasectomies, and counseling services are available through the Family Planning Service. Prenatal education and a special teen obstetrics program are also available. This center provides more than 300 risk assessments a year and counsels patients accordingly. However, it does not currently follow patients with symptomatic HIV infection.
6. The Family Health Center provides comprehensive primary care services to all members of families, including infants, children, teenagers, adults, and elders. Each family is assigned to a provider and becomes a member of a group practice which offers, in addition to the services of the family doctors and family nurse practitioners, prenatal care, well-baby cluster visits, nutritional assessment and education, family therapy, social services, podiatry, and health education. The Family Health Center also sponsors the Refugee Clinic, which is located on Ward 85. The Refugee Clinic provides initial medical screening and primary care services to patients of all ages who have Federal refugee status. The Refugee Clinic is specially focused to non-English-speaking refugees and maintains a staff with language capabilities in Vietnamese, Lao, Cambodian, Mien, Chinese, Ethiopian, Polish, Czech, and Afghan.
7. The Dental Center provides a comprehensive range of primary, secondary, and tertiary dental services at four locations: the South of Market Health Center, the Potrero Hill Health Center, the Southeast Health Center, and San Francisco General Hospital through the general dentistry and oral surgery clinics. The staff consists of dentists, oral surgeons, dental assistants, dental hygienists, and registered nurses.
8. Outpatient Substance Abuse Services at SFGH is experiencing an increase in the number of patients who have AIDS/ARC or are HIV

antibody positive. The methadone maintenance program at SFGH (Ward 93) treats an average of 175 patients each month, 23% of whom have AIDS/ARC or HIV infection. These services are discussed in more detail in the chapter on Substance Abuse Services.

Service projections for FY 1987-88 in each of the seven hospital-based centers are summarized in Table 2.

**Table 2: Encounters with symptomatic AIDS/ARC patients projected at SFGH-based outpatient clinics for FY 1987-88**

<u>CLINIC</u>	<u>Total encounters</u>	<u>Percent AIDS/ARC</u>	<u>Number AIDS/ARC</u>
Adult Medical Center	44,717	2.0	894
Adult Surgical Center (3/FL)	40,528	5.0	2,026
Adult Surgical Center (4/FL)	20,332	10.0	2,033
Children's Health Center	20,332	-	-
Women's Health Center	49,556	-	-
Family Health Center	36,523	2.0	730
Dental Center(s)	10,985	5.0	549

In sum, symptomatic AIDS/ARC patient encounters at SFGH-based outpatient centers other than Ward 86 are expected to total 6,232 in FY 1987-88. This includes screening procedures to rule out AIDS/ARC. It represents 3% of the total encounters anticipated at the clinics concerned.

The community-based satellite clinic centers associated with SFGH now assume responsibility for comprehensive health maintenance and medical management of HIV-infected patients. In an attempt to divert demand that might otherwise focus on Ward 86, SFGH has committed resources to begin the decentralization of AIDS/ARC outpatient care to these and other outlying facilities, such as Southeast Health Center and Potrero Hill Health Center. While these community clinic sites will serve as primary providers for increasing numbers of patients with AIDS or ARC, Ward 86 will continue to be utilized for sub-specialty consultation and entry into experimental treatment protocols. In addition, community-based satellite clinic centers may be increasingly called upon to provide immuno-monitoring services, treatments, and other medical services to asymptomatic individuals as the HIV positive population is provided with information about the usefulness and availability of these types of services and more treatment options are developed.

Patients may also enroll in experimental treatment protocols through community-based research studies coordinated by SFGH. Ward 86 staff will work



with primary care physicians in SFGH/UCSF programs and in the community to maintain specific control over the type and quality of medical care delivered in each facility.

All three satellite centers and Mission Neighborhood Health Center are staffed by physicians, registered nurses, nutritionists, health educators, and medical social workers or family health workers. The staff at South of Market Health Center also includes clinical pharmacists. Because of the varied levels of medical staffing in these satellites, and depending on available resources, each extension program will be molded on an individual basis.

Service projections for FY 1987-88 in each clinic are shown in Table 3.

**Table 3: Visits of symptomatic AIDS/ARC patients projected for FY 1987-88 at satellite clinics affiliated with SFGH**

<u>CLINIC</u>	<u>Total encounters</u>	<u>Percent AIDS/ARC</u>	<u>Number AIDS/ARC</u>
So. of Market Health Center	17,169	0.5	86
Potrero Hill Health Center	8,643	2.0	172
Southeast Health Center	13,770	4.9	675

In sum, AIDS/ARC patient encounters at SFGH's satellite outpatient clinics are expected to total 933 in FY 1987-88. The total includes registrations for screening procedures to rule out AIDS/ARC. This represents care for 48 patients, all of whom look to one of these clinics as their primary care provider. Of the patients seen in these settings, approximately 2.4% are persons with AIDS/ARC.

#### Clinic Services Administered by Other Subdivisions of DPH

District Health Center #1 is operated by the Department of Public Health and has served as a model for community-based primary care for AIDS/ARC patients. This health center provides a full complement of primary care services for individuals who are ill with clinical manifestations of HIV infection, referring patients to SFGH only for special diagnostic testing, certain types of therapies, experimental treatment regimens, and hospitalization. The health center holds three AIDS/ARC clinics each week. In order to be seen in an AIDS/ARC clinic, patients must first be evaluated during a Medical Drop-in clinic. There are four such drop-in clinics each week. Of the approximately 30 patients seen in each drop-in clinic, about 50% have illnesses related to HIV infection. In 1986-87 there were about 2,500 patients seen in these clinics. At any given time during the year the health center estimates that 500 patients are followed by Health Center #1 providers. Based on the 1986-87 experience, it is anticipated that those patients will make a total of 1,300-1,500 visits.



With the exception of District Health Center #1, there are no formal HIV screening services provided at the other four district health centers (#2-#5). All patients considered to be at risk, including all patients seen in women's clinics, are counseled regarding the prevention of HIV transmission. Literature about AIDS is available in all the health centers and staff are available to respond to questions as needed. Any patient who is self-identified as a person with AIDS/ARC or who presents to a clinician with symptomatic HIV infection is referred to Ward 86 at San Francisco General Hospital.

DPH's Central Emergency Aid Station (at Ivy Street) currently refers any patient with concerns about HIV infection or who may have HIV infection-related illness to Ward 86 or Health Center #1. A street outreach and evaluation program planned for early 1988 will send a team of providers (physician, nurse, and social worker) to community-based services such as 18th Street Services, the Folsom Street Hotel, the Ambassador Hotel, etc. Plans to expand the Ivy Street facility include space and staffing for an AIDS clinic. The clinic expects 35,000 urgent care visits in FY 1987-88, and a significant number of those are expected to be HIV-related in some way.

DPH also contracts with the Haight Ashbury Free Medical Clinic to offer AIDS-specific screening and primary care services (in addition to its routine primary care services) to low- and no-income individuals. Its FY 1987-88 contract calls for 11,000 patient visits, 550 of which are expected to be HIV-related. While these visits are only 5% of the total, they place a significantly greater demand on professional time and other clinic resources. An AIDS-specific clinic visit typically takes an hour and a half compared to a routine 20-30 minute visit and includes an extensive physical exam, a complete health and lifestyle evaluation, and counseling and referral as appropriate.

Jail Medical Services, a subdivision of the Department of Public Health's Division of Forensic Services, also serves persons with HIV-related disease who are incarcerated in city or county detention centers. HIV-related conditions are evaluated and treated if possible in the outpatient setting of the daily medical clinics at the three county jails. Patients with any illness which requires resources unavailable at the jail medical facilities are transferred to SFGH for care. Frequent evaluations of self-identified inmates with HIV infection are performed by jail nursing staff for early detection of opportunistic infections and other complications. Approximately 58,000 individuals will come through the jail system during FY 1987-88. Although it is not known how many of these will require medical attention related to HIV infection, this is a population that includes a significant number of non-compliant IV drug users and is therefore at very high risk of HIV infection.

DPH's Bureau of Communicable Disease Control operates a Tuberculosis Clinic at SFGH which also provides screening and primary care to persons with concomitant HIV infection.

In addition, there are a number of other clinical settings at which patients are routinely counseled regarding the prevention of HIV transmission. Patients presenting symptoms that might be HIV-related are referred to an appropriate screening and primary care clinic. These settings include: (a) the Bureau of Communicable Disease Control's sexually transmitted disease clinic, (b) health care services for the homeless, and (c) epidemiologic research projects.

### Services Based at Community Hospitals

Moffitt Long Hospital on the UCSF campus has an AIDS-dedicated outpatient clinic that cares for people with HIV-associated illnesses. This clinic now provides screening, referral, diagnosis, treatment, psychosocial support, and follow-up for these patients. In addition, various specialty clinics at Moffitt may serve as primary care providers for persons with AIDS or ARC.

The Department of Pediatrics at UCSF's Moffitt Hospital has developed an expertise in caring for pediatric and adolescent HIV-related illness. Studies done at UCSF of infants born to HIV-infected mothers indicate that approximately one third of these infants may be HIV-infected. Pediatrics is currently seeing one to two infected infants each week. This clinic also follows children who were infected by transfused blood as neonates, adolescents at high risk, and infants born to high risk mothers. This department provides much of the city's acute care and specialized testing for pediatric and adolescent patients.

Two community hospitals have developed AIDS-dedicated outpatient services, and others provide primary care to persons with HIV infection in their more traditional ambulatory care clinics. Those with AIDS-dedicated clinics are Mt. Zion and Kaiser-Permanente (an HMO). The range of services provided is similar to those available at San Francisco General Hospital. There has been an energetic, cooperative education and training effort on the parts of these community hospitals and San Francisco General. The purpose of these efforts is to share SFGH's experience in the evolution of its AIDS primary care programs to enable the hospitals to provide high-quality, sensitive care to patients with very complex medical and social problems. Patients are referred to these hospitals for outpatient care from both San Francisco General and private physicians.

Davies Medical Center has a AIDS-dedicated outpatient program for infusion therapy and the administration of aerosolized pentamidine. Primary care is provided by physicians in private practice associated with this center.

The Veterans Administration Medical Center (VAMC) regional hospital provides a full range of medical services for people with HIV infection. Although there is no dedicated AIDS clinic, patients may be seen in all clinic settings, including general medical, outpatient psychiatric, outpatient substance abuse treatment, etc. The VAMC estimates that it currently provides primary care to approximately 200 individuals who have HIV infection, AIDS, or ARC.



With the exception of the VAMC, data on encounters, numbers of patients followed, and costs at these clinics are not currently available.

### Services of Physicians in Private Practice

It is estimated that physicians in private practice serve as the primary care provider for the majority of people with HIV-related illness. Although there are no specific data available to define precisely the dimensions of their role in the care of AIDS/ARC patients, it is evident from data on community hospital inpatient services, which account for 67% of the inpatient admissions for persons with AIDS/ARC in San Francisco, that their role is very significant.

### C. FACTORS INFLUENCING SERVICE CONFIGURATIONS

1. As community clinics begin to see more people with HIV infection-related illness, it will become necessary to spend time and resources dealing with the psychosocial concerns of both the clinic staff and patient population. In addition, as the number of people who are aware of their antibody status increases, community clinics will be called upon to provide both education and medical care (e.g. immunomonitoring or T4 testing) for HIV positive asymptomatic individuals.
2. The population groups requiring treatment are expected to become more diversified. The preponderance of current cases of both AIDS and ARC is among white gay and bisexual men. The vast majority of reported cases with a history of IV drug use are also white gay/bisexual men. While DPH anticipates that in the next five years most new cases of CDC-defined AIDS will be from the groups mentioned, we will also probably see an increase in AIDS/ARC cases who are (a) from racial and ethnic minority groups (both gay/bisexual and non-gay/bisexual), (b) women, (c) infants, (d) substance abusers (both gay/bisexual and non-gay/bisexual), and (e) jail inmates. Serving these populations may require different service configurations and different settings for services.
3. There are new patterns in the clinical manifestations of AIDS. For example, there is an increasing incidence of unusual cancers and a marked increase in the incidence of neurological impairment. These new patterns will require different treatments and different support services.
4. New treatments are being developed. New drugs will prolong life expectancy and therefore expand demands for health care services. New treatment regimens will create demands for different staffing, space, and equipment, primarily in outpatient service settings.



5. As treatment is further decentralized, it will be increasingly important to ensure that clinical trials of experimental therapies are available to patients of clinical settings outside of SFGH.
6. DPH also anticipates an increase in dependence on public-sector support. Patients will live longer, and more will "spend down" to eligibility for greater public assistance. Some may live long enough to qualify for Medicare.
7. DPH has instituted infection control policies that require universal body-substance precautions. The implementation of these guidelines may increase the fears of providers in primary care and specialized outpatient care settings and increase the cost of care in these programs.
8. As the number of pediatric and adolescent AIDS cases increases, there will need to be a comparable increase in pediatricians and other clinicians with the expertise to care for these patients. The medical management of these patients is often unique and more complicated than that of adults. In addition, the development of experimental treatment protocols designed specifically for children will become an increasingly important issue.
9. The California Department of Health Services (DHS) has commissioned studies of the need for special health care and psychosocial support in racial and ethnic minority communities. They are scheduled for completion in 1988. They may have implications for planning future clinical screening and outpatient services in San Francisco.
10. Given the present political climate and current levels of State/Federal interest and initiative, it seems questionable that the allocation of State and Federal resources to health care for persons with AIDS/ARC will keep pace with the demand. The California Medicaid program, through which most State and Federal resources are expected to be made available for the care of AIDS/ARC patients dependent on the public sector, has been slow to recognize the need for revised rates and expanded service configurations.
11. The California Medicaid program continues to deny coverage for "experimental services, including drugs and equipment", in the treatment of AIDS patients. Gancyclovir therapy for CMV retinitis is a case in point. In situations where experimental drugs are the only ones available, such denial is not only inequitable but leaves the burden of care entirely on local resources.
12. Because San Francisco's local government support for the care of AIDS/ARC patients was initiated during a time of budget surplus, the programs developed for AIDS/ARC care did not result in a

concomitant reduction in programs addressing other health care needs. The surplus has been used up. Further expansion of services depending on local tax dollars cannot be anticipated without some reduction in other city services. The backlash of such a reduction in other health care services may negatively affect AIDS care, as providers and clients with other needs advocate more aggressively for comparable support. Comprehensive care of the AIDS patient and continued attention to avoiding duplication of services will be important.

13. Public policy and sentiment regarding HIV antibody testing continues to shift. New legislation is introduced every session that calls for mandatory testing of various subpopulations in our communities. The impact of mandatory testing may be to drive individuals away from care provided in established hospital- and community-based clinics.
14. It is apparent that the insurance lobby is encouraging the State Legislature to approve a bill that would allow insurance companies to request HIV antibody testing of applicants. This would mean that many individuals would be denied insurance, and possibly some who are currently insured might lose their coverage, forcing them into the public sector for services. In addition, as the number of minority and IV drug-using AIDS cases increases, a higher proportion of those alive and needing care will be poor.
15. With the realization that the majority of HIV-infected individuals will probably develop AIDS over time and the commencement of anti-viral trials in asymptomatic and mildly symptomatic HIV-infected patients, there will be an increased demand for HIV antibody testing for purposes of early diagnosis and treatment. There also will be an increased demand for medical care of asymptomatic and mildly symptomatic HIV-infected patients, potentially creating a large new service gap.

#### D. POLICY REAFFIRMATION

1. DPH will maintain its general focus on comprehensive outpatient care and maximize patients' potential to maintain themselves at their optimal functioning capacity at home or in residential facilities.
2. DPH will ensure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture, and language should be evident in all service settings. The special needs of women with AIDS/ARC and dependent children should be taken into account.

3. Private physicians, dentists, and other primary care providers should participate as fully as possible in the diagnosis and care of persons with clinical manifestations of HIV infection and with asymptomatic HIV infection.
4. To promote this participation, DPH/SFGH will offer opportunities to private physicians, dentists, and other primary care providers to learn about our experience and to share their experience in providing care to AIDS, ARC, and HIV-infected patients.
5. Any physician who accommodates the provisions of AB 403 can order an HIV antibody test with the informed consent of his/her patient. DPH will do the necessary laboratory work free of charge for any physician who agrees to certain guidelines regarding pre- and post-test education and counseling. The sera sent to the Lab for such testing should continue to be identified by code number alone; only the physician concerned should have a record of the patient associated with the code number.
6. DPH will design a system-wide evaluation of primary care programs, using a methodology that collects information about patient satisfaction with existing programs.
7. DPH will provide leadership in the community as an advocate for adequate resources for people with AIDS, ARC, and HIV infection that ensure culturally and linguistically appropriate services.
8. DPH, recognizing that medical care of persons with asymptomatic and mildly symptomatic HIV infection will become an increasingly important aspect of outpatient care, will provide leadership in designing, seeking funding for, and implementing clinical services for this patient group.





## X. HOSPITAL INPATIENT CARE

### A. GOALS AND ACTIVITIES

It has been noted in earlier chapters that the focus of San Francisco's care for persons with AIDS and other clinical manifestations of HIV infection has been on serving patients effectively outside of acute care inpatient settings. While the model's emphasis is on comprehensive outpatient services and an extensive network of complementary support programs, the availability and viability of appropriate inpatient care, when needed, is critical to the effectiveness of the continuum. When functioning as a coordinated whole, this continuum ensures care that is at all times medically appropriate, psychosocially supportive, sensitive to lifestyle and cultural differences, and cost effective.

Effective inpatient care for persons with HIV-related illnesses requires the creation of an inpatient care setting which:

- (1) accommodates the special needs of patients who may be dealing concurrently with debilitations caused by a variety of infections and malignancies, as well as with issues related to death and dying;
- (2) promotes good communication with, and easy access to, outpatient and community support services; and
- (3) engages family, lovers, and friends as fully as possible in the process of caring for and supporting those with the illness.

### B. CURRENT SERVICES

Inpatient care for persons with AIDS/ARC (PWAs/ARC) is now provided by 13 of the 15 general acute care hospitals in San Francisco. Of the 13, three are government-run: the City/County operates San Francisco General Hospital and the Federal government operates Letterman (U.S. Army) Hospital and the Veterans Administration Medical Center (VAMC). Nine are private not-for-profit community hospitals and one is operated by the University of California at San Francisco (UCSF). Access to Letterman and the VA Hospital is restricted to active or former military personnel and their dependents, and both hospitals serve as regional centers for veterans. The VAMC is a resource center for veterans and their dependents affected by AIDS. It estimates that anywhere from 4 to 12 people with HIV infection are receiving inpatient care at any given time. According to the California Health Facilities Commission's annual report for FY 1985-86, the licensed bed capacities of the other general acute care facilities serving persons with AIDS and ARC range from 215 to 560 and total 4,443. The report also indicates actual average available beds in these facilities range from 188 to 560 and total 3,766.

The circumstances under which persons with AIDS/ARC are admitted as inpatients to each facility vary, depending on the patient's needs, the admitting physician's training and experience, the outpatient service resources available to the physician and patient, and the source of payment.

The balance of this section on current services is divided into five parts:

- (1) A discussion of sources of data, their usefulness, and their implications for projecting future service demands.
- (2) A discussion of the distribution of AIDS/ARC patients among counties and, within San Francisco, among the facilities providing general acute inpatient care.
- (3) A review of the data on demand for inpatient services and its relationship to the number of persons reported as having AIDS who are alive at any given time.
- (4) A review of data on charges, reimbursements, and costs related to inpatient care for persons with AIDS/ARC.
- (5) A description of inpatient services provided at San Francisco General Hospital.

#### (1) Sources of Information

The West Bay Hospital Conference (WBHC) has been collecting data about acute inpatient care for persons with AIDS/ARC in the West Bay since 1982. In October 1987, it released a report which adds new data from 1985 and 1986. The report, authored by health care consultant Frances Strychaz, presents and analyzes inpatient discharge data from 27 acute care hospitals in Marin, San Francisco, and San Mateo counties.

The source of WBHC's data is the Hospital Council of Northern California's Patient Data System. Except where specifically noted otherwise, all of the figures indicated below have been drawn or extrapolated from this data base. The files that were the subject of the WBHC report were created by a diagnostic screen of all patients hospitalized in the West Bay hospitals with a diagnosis using International Classification of Diseases 9th Code Manual definition of HIV infection in any position (primary, secondary, etc.). All 16 positions on the discharge reporting form which may reflect a diagnosis were screened in each file. Unfortunately, no 1987 services are reflected in the data currently available from this source.

It should be noted here that the data and resulting analysis offered by WBHC provide the clearest picture available to date of the demand for and provision of acute inpatient care for people with AIDS/ARC in San Francisco. The few opportunities we have to compare the WBHC picture with reliable information from other sources suggest that the WBHC picture needs to be reviewed with the following observations in mind:



1. The WBHC report does not include data from either Letterman (U.S. Army) Hospital or the Veterans Administration Hospital in San Francisco. These two hospitals are the source of reports of 3.4% of the AIDS diagnoses in San Francisco County to date. It should probably be assumed that these two facilities account for a similar proportion of the average daily inpatient census of AIDS/ARC patients in the county.
2. Because the WBHC data depend entirely on the screening of diagnostic codes, the accuracy of the picture of AIDS/ARC patients' need for hospital care which is created by these data depends on how sensitive and specific the codes are. For example, if a physician does not clearly write HIV or AIDS, the abstractor will not find it.
3. Tabulations of data related to particular periods of time sometimes reflect data recorded during the period in question. At other times it may reflect data about services provided during the period. The same can be true for cost data.

## (2) The Distribution of AIDS/ARC Patients

### Distribution of AIDS/ARC inpatient care among counties

From the WBHC report, Table 1 on the next page indicates the county of residence of patients discharged from general acute care facilities located in San Francisco. The breakdown provided by WBHC indicates all presentations of aggregate data including discharges from Garden Sullivan Hospital, a specialty care facility which provides "step-down" care. All of the other hospitals listed provide general acute care. Since Garden Sullivan services are discussed in more depth in the chapter on Chronic Care and Related Support Services, WBHC figures have been adjusted here and in all other tables to reflect general acute care only.

Table 1: Residence of AIDS/ARC patients  
in all general acute care community hospitals in San Francisco

<u>County of residence</u>	<u>1985 discharges</u>	<u>1985 percent</u>	<u>1986 discharges</u>	<u>1986 percent</u>
San Francisco	1559	88.8	2401	88.3
East Bay	77	4.4	124	4.6
San Mateo	32	1.8	29	1.1
Marin	14	0.8	38	1.4
Santa Clara	9	0.5	10	0.4
Other	65	3.7	116	4.2
<b>TOTALS</b>	<b>1756</b>	<b>100.0</b>	<b>2718</b>	<b>100.0</b>

Where patients of San Francisco General Hospital in particular are concerned, the report shows the following for counties of residence (Table 2):

Table 2: Residence of San Francisco General Hospital's AIDS/ARC general acute care patients

<u>County of residence</u>	<u>1985 discharges</u>	<u>1985 percent</u>	<u>1986 discharges</u>	<u>1986 percent</u>
San Francisco	551	90.6	821	92.5
Other counties	57	9.4	67	7.5
TOTALS	608	100.0	888	100.0

The general observation that 88% or more of AIDS/ARC patients in San Francisco hospitals are also residents of San Francisco County is consistent with the findings of a much smaller study conducted by the San Francisco Department of Public Health's AIDS Surveillance Branch in 1987. The latter found that 88% of AIDS/ARC patients in-house in seven San Francisco hospitals on July 23, 1987 had San Francisco addresses. Of the 34 patients in-house at San Francisco General Hospital on that day, none were listed as residents of other counties.

Of the 1579 AIDS/ARC discharges from all West Bay hospitals in 1985 who were residents of San Francisco, 20 (1.3%) were cared for outside of San Francisco. Of the 2429 in 1986, 28 (1.2%) were cared for outside of San Francisco.

Notwithstanding these figures and their confirmation, the WBHC report also points out that. . .

" . . .there is a reasonable concern that the use of hospital patient origin data for analysis of incidence of projection of needs for AIDS care bears some greater limitations than for such uses with respect to other illnesses. Given the relative newness of the disease and the concentration of experienced providers of AIDS care in select urban areas, it is generally considered that individuals with AIDS or ARC will more readily move upon diagnosis to obtain appropriate care more easily. And there is of course no way of knowing from the automated portion of the hospital record how long patients reporting a local address have in fact been residents of the area."

#### Distribution of AIDS/ARC inpatient care among San Francisco hospitals

The WBHC report also breaks down patient discharges in 1985 and 1986 by hospital (Table 3). The San Francisco hospitals listed are ranked according to the number of discharges in 1985. In only two instances does the ranking

change between 1985 and 1986: the four institutions accounting for less than 3% of AIDS/ARC patients each shifted up or down one position on the scale.

**Table 3: Distribution of AIDS/ARC inpatient care among San Francisco hospitals**

<b>SAN FRANCISCO HOSPITAL</b>	<b>1985 discharges</b>	<b>1985 percent</b>	<b>1986 discharges</b>	<b>1986 percent</b>
SF General	608	34.6	888	32.7
RK Davies	285	16.2	486	17.9
Pacific-Presbyterian	222	12.6	305	11.2
Kaiser SF	217	12.4	327	12.0
UCSF	131	7.5	234	8.6
Children's	75	4.3	123	4.5
St. Francis	57	3.2	101	3.7
Mt. Zion	51	2.9	76	2.8
Marshall Hale	44	2.5	45	1.7
St. Luke's	33	1.9	66	2.4
St. Mary's	17	1.0	33	1.2
French	16	0.9	34	1.3
<b>TOTALS</b>	<b>1756</b>	<b>100.0</b>	<b>2718</b>	<b>100.0</b>

### (3) Relationship of Inpatient Service Need to Number of Living PWAs

Of particular interest in the WBHC report is information about the growth in AIDS inpatient care volume by county of hospital from 1984 through 1986. The discharge and average daily census data for San Francisco County are presented in Tables 4-6, juxtaposed to the average number of persons with AIDS reported to be living in San Francisco during the year. There seems to be a relatively consistent pattern in the relationship between the number of living PWAs and the demand for general acute care services. The gradual drop in the pattern probably reflects an increase in the availability of services needed to maintain patients outside of acute care settings.



Table 4: Acute care discharges of PWAs/ARC compared to living PWAs in San Francisco: 1984-1986

<u>YEAR</u>	<u>Discharges PWAs/ARC</u>	<u>Average number living PWAs</u>	<u>Ratio discharges/PWAs</u>
1984	1061	391	2.71
1985	1756	706	2.48
1986	2718	1073	2.53

Table 5: AIDS/ARC inpatient days compared to living PWAs in San Francisco: 1984-1986

<u>YEAR</u>	<u>Inpatient days</u>	<u>Average number living PWAs</u>	<u>Ratio inpatient days/PWAs</u>
1984	11939	391	30.5
1985	19638	706	27.8
1986	28113	1073	26.2

Table 6: AIDS/ARC average daily inpatient census compared to living PWAs in San Francisco: 1984-1986

<u>YEAR</u>	<u>Average daily census (ADC)</u>	<u>Average number living PWAs</u>	<u>Ratio ADC/PWAs</u>
1984	32.7	391	.084
1985	53.8	706	.076
1986	77.2	1073	.072

The very consistent pattern in the ratio of discharges, inpatient days, and average daily inpatient census to the number of living persons with AIDS known to be residing in San Francisco suggests that it is reasonable to base service needs projections on this base number (i.e. the number of people living with AIDS at any point in time).

#### (4) Charges, Reimbursements, and Costs Related to Inpatient Care

In the Byzantine world of hospital finance, the relationships among charges, reimbursements, and costs are invariably difficult to assess. The

problem is exacerbated by the fact that those discussing these issues frequently use the terms interchangeably, sometimes out of ignorance and other times to keep illusions alive. For example, Medicaid and Medicare program staff frequently insist on using the term "costs" when they are talking about reimbursement rates. It should be noted that reimbursement rates are usually set at less than "cost". In relation to care for AIDS patients, the problem is further complicated by the fact that standards of practice are still evolving. Consequently, even in well-organized and well-managed settings, charges assigned and payments provided for AIDS patient care are often tied to cost analyses and provider experience which bear little relationship to the grim realities of AIDS.

The WBHC report includes aggregate data on total charges for each patient (Table 7), which California hospitals are required to report to the State. These data, the author cautions, "do not reflect actual cost or revenue, but in the absence of special studies, they represent the only source of areawide hospital data that approximate cost for select diagnostic groups."

Table 7: Average charges for AIDS/ARC acute inpatient care in San Francisco hospitals (exluding Kaiser Hospital)

<u>YEAR</u>	<u>Charges per patient day</u>	<u>Total charges at discharge</u>
1984	\$881	\$ 9,804
1985	\$913	\$ 9,942
1986	\$936	\$10,758

Table 8: All San Francisco AIDS/ARC inpatient discharges by principal payor charged

	<u>1985</u>	<u>Percent</u>	<u>1986</u>	<u>Percent</u>
Medicare	41	2.3	95	3.5
MediCal	507	28.9	835	30.7
Private indemnity	724	41.2	1046	38.5
Other (includes HMOs, "self pay", etc.)	484	27.6	742	27.3
<b>TOTALS</b>	<b>1756</b>	<b>100.0</b>	<b>2718</b>	<b>100.0</b>

#### (5) Inpatient Services for Persons with AIDS/ARC at SFGH

##### SFGH's inpatient unit dedicated to AIDS: 5A

The concept of a dedicated unit for AIDS care was pioneered at San Francisco General Hospital (SFGH) in 1983. Most AIDS/ARC patients at SFGH are

accommodated in a 20-bed unit, 5A. The expansion to 28 beds proposed for 1987-88 has not yet occurred. When this dedicated unit is full, AIDS/ARC patients are assigned to other medical-surgical units on a space-available basis. The staff based at 5A become involved in the care of all AIDS/ARC patients in the hospital regardless of the unit where a patient is located. They provide both technical and emotional assistance to the regular staff of other units.

Unit 5A at SFGH is special in the following ways:

- Staff serving on the unit volunteer to do so.
- Shanti Project counselors are available to provide emotional support to patients and visitors and to facilitate the making of decisions about treatment and responses to changes in clinical status.
- Staff and volunteers of community-based organizations who work with PWAs/ARC outside the inpatient setting initiate or maintain their involvement with patients while they are on the unit.
- The structure of the unit supports a broader than usual range of staff-patient interactions (e.g. the unit has a single lounge for staff, patients, and their visitors).
- It provides a focal point for individuals and community groups that wish to contribute to the care of AIDS/ARC patients (e.g. it is the site of potluck dinners, recitals).
- An extensive chaplaincy program provides spiritual support for patients, their families, and significant others.

#### Other inpatient units with a special focus on AIDS/ARC

Certain inpatient units other than 5A at SFGH have become increasingly involved in caring for persons with HIV-related illness. For example, Unit 7B has developed an AIDS Focus Program which provides inpatient psychiatric care for AIDS and ARC patients in a locked setting. Presented clinical syndromes include depression with suicidal acts, acute psychosis, and dementia. The medical needs of these patients have required both additional nursing care and a different type of nursing care than normally provided in psychiatric units. Disposition has been a particularly difficult issue for demented AIDS patients, and this has resulted in an inordinately long length of stay for some patients. Currently, from four to six patients with AIDS or AIDS-related conditions are treated in this unit at any one time. Staff working with the AIDS Focus Program volunteer to do so.

The staff on 7B also serve as psychiatric consultants to staff on Unit 5A and to the AIDS outpatient clinic, Ward 86. Fifty-six patients have been



admitted to Unit 7B from January through November 1987; 9 were admitted more than once. The length of stay ranges from seven days to six months. Those admitted for an acute crisis (39%) averaged 8.5 days. Those admitted for severe dementia (61%) averaged 31 days. Records indicate that 22% have some history of IV drug use.

#### Other services contributing to AIDS/ARC inpatient care at SFGH

Various subdivisions of the hospital contribute significantly to the care provided on 5A and other units serving persons with AIDS/ARC. They include such medical services as anatomic pathology, surgery, gastrointestinal medicine, psychiatry, neuropsychiatry, family practice, general medicine, medicine, endocrinology, and nephrology. This array of specialized services provides diagnostic, therapeutic, and consultative services in support of acute inpatient care.

To ensure appropriate and expert medical care for persons hospitalized with HIV-related illnesses, the range of support services must also include the various analytical laboratories, medical social services, physical therapy, respiratory therapy, and pharmacy. A number of administrative support operations contribute as well: infection control, medical records, housekeeping, employee health services, and the medical library.

Although SFGH does not tabulate how many AIDS/ARC patients are admitted as inpatients following a visit to the emergency room, it is believed that the number who use emergency room services may create a significant cost factor in providing care to persons with AIDS or ARC.

#### AIDS/ARC inpatient census at SFGH

The WBHC report provides some data that are specific to San Francisco General Hospital. Based on the average number of persons expected to be living with AIDS in 1987-88, and factoring in (a) the anticipated demand for inpatient services suggested by the WBHC data and (b) patterns that seem to be specific to SFGH, the following projections have been developed for SFGH (Table 9):

**Table 9: AIDS/ARC patients expected to be hospitalized at SFGH during FY 1987-88**

<u>UNIT/WARD</u>	<u>Total admissions</u>	<u>Avg. daily census</u>	<u>Avg. length of stay</u>	<u>Patient days</u>
Unit 5A	732	19.9	9.9	7,247
Other Med/Surg	602	15.2	9.2	5,556
Unit 7B	74	3.1	15.5	1,116
TOTALS	1,406	38.1	9.9	13,919

Charges and principal payors charged at SFGH

It has already been noted that charges, reimbursements, and costs can be and usually are very different amounts when it comes to hospital finances. But, the only data available at this point are data about charges filed with the Hospital Council of Northern California's Patient Data System. However many disclaimers it may take to keep the figures in proper perspective, we seem obliged to cite these charges as the best indicator we have at this time of the dollars needed to support inpatient services.

Here is a recap of data generated by SFGH:

**Table 10: Average charges for AIDS/ARC inpatient care  
at San Francisco General Hospital**

<u>YEAR</u>	<u>Charges per patient day</u>	<u>Total charges at discharge</u>
1984	\$ 702	\$ 8261
1985	\$ 672	\$ 7995
1986	\$ 770	\$ 9131
1987	\$ 842	\$ 8301

**Table 11: San Francisco General Hospital  
AIDS/ARC inpatient discharges by principal payor charged**

	<u>1985</u>	<u>Percent</u>	<u>1986</u>	<u>Percent</u>
Medicare	15	2.5	34	3.8
MediCal	369	60.7	566	63.7
Private indemnity	102	16.8	123	13.9
Other (includes MIAs, "self pay", etc.)	122	20.0	165	18.6
<b>TOTALS</b>	<b>608</b>	<b>100.0</b>	<b>888</b>	<b>100.0</b>

## C. FACTORS INFLUENCING HOSPITAL SERVICE DEVELOPMENT OVER THE NEXT FIVE YEARS

## Relationship to other services

1. It has been stated that it is San Francisco's general goal to minimize the amount of time persons with AIDS and other clinical manifestations of HIV infection spend in costly acute care inpatient settings. Achievement of this goal depends on the availability and viability of comprehensive outpatient services and an extensive network of complementary support programs. All of the factors identified in the other chapters describing services to persons who are ill (e.g. Primary Care Services, Chronic Care, Housing and Related Support Services, Substance Abuse Services, and Mental Health Services) pertain here as well.
2. AIDS is an infectious disease. Even though epidemiologists are in general agreement that the virus is very difficult to transmit, many health care workers fear contagion from work-related contact. Effective inpatient care depends on (a) the development and implementation of infection control guidelines that are both practical and reassuring to health care workers in hospitals, and (b) adequate training about AIDS and infection control for all workers involved with HIV-infected patients.
3. Ensuring high-quality care by health care professionals also requires regular psychosocial support for medical staff to assist them with the extraordinary stress of caring for patients with difficult medical management problems, with their fears about the possibility that they might be infected, and with their grief about the many patients who are dying every day. Nurses probably spend more time with patients than most other care providers and therefore are particularly vulnerable to these stresses. Since there is currently a national shortage of nurses, it is very important to provide support for the nursing staff to reduce "burnout".
4. The constructive involvement of private community hospitals in caring for AIDS/ARC patients depends on several major factors: (a) the availability of physicians in private practice whose training and professional support system encourage their working with AIDS/ARC patients; (b) easy access to experimental drug trials for AIDS/ARC patients of physicians in private practice; (c) easy access to community-based support services for AIDS/ARC patients of physicians in private practice; and (d) third party reimbursements (public as well as private) that cover the real costs of providing both outpatient and inpatient care to persons with AIDS/ARC. If community hospitals are effectively engaged in the care of AIDS/ARC patients, there are probably enough acute care beds available in San Francisco to meet the demand anticipated between 1988 and 1993.



Clinical manifestations and treatment regimens

5. New patterns in the clinical manifestations of AIDS continue to evolve. The marked increase in the incidence of neurological impairment is the most dramatic example. These new patterns will require new and different treatment as well as different support services. The role that inpatient care will play in these new patterns is not yet clear.
6. New treatments are being developed. New drugs will prolong life expectancy and therefore expand demands for health care services. New treatment regimens may create demands for different staffing, space, and equipment, primarily in outpatient service settings but perhaps in inpatient settings as well. Although the anticipated impact of AZT has been factored into current projections of service needs, the impact of other possible therapies has not.

It is also evident that, as more therapies become available, it will be necessary to improve education and information dissemination regarding the available alternatives and access to them.

Demographic distribution of patients

7. Although the seroconversion rate among gay/bisexual men in San Francisco has dropped to less than 4% per year and there is some evidence that the seroconversion rate among IV drug users in San Francisco is approximately 3% per year, the number already infected with HIV is large.
8. Since it is anticipated that more IV drug-using patients will be in need of services in coming years, it will be important to recognize that the needs of these patients may be different from others. Because IV drug users typically seek service only after they are very sick, once they are admitted to the hospital they require a high level of care and often die there. For those who could potentially receive care in a less acute setting it is extremely difficult to find placement for them since most housing and subacute settings will not accept patients with IV drug-using histories.
9. Although the distribution of cases among population groups requiring treatment is not expected to change significantly, the actual numbers in currently low-incidence groups are expected to increase dramatically. The preponderance of current cases of both AIDS and ARC is among white gay and bisexual men. The majority of reported cases with a history of IV drug use are also white gay and

bisexual men. While DPH anticipates that in the next five years most new cases of CDC-defined AIDS will also be from these groups, the incidence of AIDS among (a) members of racial and ethnic minority groups (both gay/bisexual and non-gay/bisexual), (b) women, (c) non-gay/bisexual substance abusers, and (d) jail inmates may require new service configurations or modifications of existing service delivery systems.

10. The problem of appropriate inpatient care for infants, children, and adolescents will become an increasingly important issue. Children with HIV infection-related illnesses typically require lengthy hospitalizations, for example.
11. The California Department of Health Services (DHS) has commissioned two studies of the need for special health care and psychosocial support in racial and ethnic minority communities. In San Francisco the studies are being conducted by the Instituto Familiar de la Raza in Latino communities and Westside Community Mental Health Center in Black communities. Neither study is scheduled for completion before June 1988. These may have implications for planning future inpatient care services in San Francisco.

#### Payment sources

12. Some people with AIDS/ARC may live long enough to qualify for Medicare, and/or Medicare regulations may be revised to shorten the period between diagnosis and eligibility.
13. Patients with certain clinical manifestations of ARC sometimes require as much care and support as patients with AIDS, yet they are not presumptively eligible for MediCal, SSI, etc. This tends to make them more dependent on local public resources. The expanded definition of clinical AIDS recently issued by the Centers for Disease Control (September 1987) has reduced the proportion of those disabled by HIV disease who are not formally classified as having AIDS. However, some will still fall into this category of severe ARC not presumptively eligible for MediCal, SSI, etc.
14. DPH anticipates a general increase in dependence on public-sector support. Patients will live longer, and more will "spend down" to eligibility for greater public assistance.
15. The California Medicaid program continues to deny coverage for "experimental services, including drugs and equipment" in the treatment of AIDS patients. Gancyclovir therapy for CMV retinitis is a case in point. In situations where experimental drugs are the only ones available, such denial is particularly difficult to accommodate.



16. Given the present political climate and current levels of State/Federal interest and initiative, it seems unlikely that the allocation of State and Federal demonstration project grants for inpatient care for persons with AIDS/ARC will keep pace with the demand. The California Medicaid program, through which most State and Federal resources are expected to be made available for the inpatient care of persons with AIDS/ARC dependent on the public sector, has been extremely slow to recognize the need for revised rates. Some form of special reimbursement for hospitals that are accommodating a disproportionate number of AIDS/ARC patients is being sought.
17. Because San Francisco City government support for the care of AIDS/ARC patients was initiated during a budget surplus, the programs developed for AIDS/ARC care did not result in a concomitant reduction in other health care programs. The surplus has been used up. Further expansion of services dependent on local tax dollars cannot be anticipated without some reduction in other city services.

Information available about services and costs

18. Reliable and quantifiable information about inpatient services engaged in the care of AIDS/ARC patients is very difficult to find. Much of the information collected and analyzed by the West Bay Hospital Conference (number of discharges by diagnosis, number of patient days per stay, average length of stay, distribution by hospital and by county) is extremely useful. Other information about charges and presumed payment source is acknowledged to be of marginal use, since it does not show actual costs or the level or source of actual payments. In short, WBHC's reports do as much to underscore the need for more quality information as they provide in information.
19. SFGH has been able to supplement studies such as WBHC's in limited ways. Specific questions that remain unanswered include: (a) what inpatient care for persons with AIDS/ARC actually entails (including but not necessarily limited to ancillary and support services which are covered by the hospital's budget), (b) what the actual costs are, and (c) how those costs are paid. These are all questions for which the database available to WBHC cannot provide answers. The absence of such information, or plans for assembling such information from the acute care institution with the most experience with AIDS/ARC patients, seriously inhibits planning for the epidemic.
20. UCSF's Institute for Health Policy Studies, under contract with the California Department of Health Services, has undertaken a state-wide study of the cost of caring for persons with AIDS/ARC.



D. POLICY REAFFIRMATION

1. DPH will maintain its general focus on comprehensive outpatient care and maximize patients' potential to maintain themselves at their optimal functioning level at home or in residential facilities. The demand for inpatient care is directly related to the availability and quality of outpatient care, housing, and in-home support services.
2. DPH should ensure that hospital services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, race and ethnicity, culture, and language should be evident in all service settings. The special needs of women with AIDS/ARC and dependent infants, children, and adolescents should be taken into account.
3. Physicians in private practice and the community hospitals to which they admit patients should be encouraged to participate as fully as possible in the screening and care of persons with clinical manifestations of HIV infection. DPH recognizes that the proportion of AIDS/ARC patients admitted to private community hospitals will depend on the proportion of AIDS/ARC patients whose primary care is being provided by physicians in private practice.
4. SFGH should develop a management information system which efficiently identifies and tracks the demand for various services specific to AIDS/ARC patients, their costs, and the extent to which they are covered by third party payors.
5. DPH will continue its commitment both to providing AIDS-specific training for health care personnel, and to providing routine and continuing psychosocial and emotional support for hospital staff.
6. DPH recognizes the need for an aggressive campaign to educate HIV seropositives about developing medical options and the corollary need to coordinate provision of access to these options.



## XI. CHRONIC CARE, HOUSING, AND RELATED SUPPORT SERVICES

### A. GOAL

The general goal of San Francisco's chronic care and related support services for people with AIDS or ARC is identical to the goal of primary and acute care services: to provide care for patients in a manner which is medically appropriate, psychosocially supportive, culturally sensitive, linguistically appropriate, and cost effective. In San Francisco the median survival of AIDS patients from diagnosis to death is approximately 12 months. Of this period roughly 35 days are spent in the hospital. For the remaining 11 months, patients are often fairly ill, with a range of medical needs. An extensive network of complementary services is required to maximize patients' potential of maintaining themselves effectively outside of acute care settings.

### B. DEFINITIONS OF SERVICE ELEMENTS

1. "Subacute care" and "skilled nursing care" are variations on the theme of licensed health care in a post acute care setting that provides 24-hour monitoring by a nursing staff when patients' conditions are relatively stable and not likely to require heroic interventions. In certain circumstances, the terms are used to identify different categories of licensing, different levels of patient acuity and staffing requirements, and different reimbursement rates. Persons with AIDS and disabling ARC who require such care are often more debilitated than patients traditionally cared for in these settings. They are also sometimes subject to sudden and dramatic changes in status, and therefore require a higher-than-usual level of staff support than most patients in these facilities.
2. Housing for persons with AIDS/ARC: At any point in time, most people with AIDS and ARC are able to live outside of an acute or subacute setting. Depending upon the course of the illness, however, varying levels of health and social support services are necessary to help people with AIDS and ARC live with the greatest degree of independence possible. Most people with AIDS/ARC are able to maintain their own housing, with support from lovers, family, and friends. Housing programs for people with AIDS and ARC who cannot manage entirely on their own resources are generally divided into three general categories: (a) long-term housing for those who are unlikely to manage well in a living situation without 24-hour staff support; (b) long-term housing for those capable of living cooperatively with others without 24-hour staff support; and (c) short-term, emergency housing for those still in fairly good health and able to function independently while looking for more permanent arrangements. Corresponding to each of these levels of



supported housing is the need to develop programs that target special populations with unique configurations of requirements, such as families, children, people who require a special physical environment (e.g. wheelchair ramps), and people with concurrent mental health or substance abuse problems.

3. In-home assessments are generally conducted by public health nurses for patients who are home-bound but who have not been admitted to a home care program. Such patients may require some assistance in understanding their need for medical care or support services and in securing such services once the need is identified. In FY 1986-87 DPH began a pilot project of in-home assessments by physicians and psychiatrists in certain circumstances.
4. Where HIV-related infections are concerned, home health care and in-home hospice care often go hand in hand. In some instances, the care is provided to a patient recovering from an episode of pneumonia, and the care consists largely of intermittent monitoring of improvement in health status. In most instances, however, in-home care is for patients who are in the terminal phases of the disease, extremely debilitated, and focused on the dying process. Effective care under these circumstances usually requires that the patient have a viable personal support system with which the in-home hospice provider can work.
5. "Practical support" is a catch-all term which encompasses a wide range of essential services that help people with varying degrees of illness maintain themselves at home for as long as possible. It includes such daily activities as grocery shopping, laundry, cleaning, meal preparation, child care, transportation to medical and social service appointments, etc. It also includes assistance with money management to ensure payment of regular and necessary expenses to help maintain stable housing. These services are often a lifeline to people with limited social support networks.
6. Emotional support for someone confronted by a life-threatening illness is particularly complex. San Francisco's response to the need for such support includes crisis intervention, psychotherapy, support groups, and peer counseling for the person with AIDS/ARC, and the same range of support services for members of their personal support systems.
7. Social services and entitlement program advocacy are integral parts of many organized health care services: acute care hospitals and subacute care facilities all provide access to a network of social services for their patients/clients while they are being cared for and before they are discharged. Home health care providers are closely linked with social service agencies that offer an array of services. Health care facilities also typically provide advocacy and assistance that may be independent of an individual's social

service needs. San Francisco funds a comprehensive program through the San Francisco AIDS Foundation which provides client advocacy and assistance for those not yet or not currently connected to an organized health care service.

8. Legal education, referral, and advocacy are often associated with social service and entitlement programs. Where AIDS is concerned, there are special dynamics which require a more focused program. For example, AIDS-related discrimination in employment and housing occurs in San Francisco in spite of an extensive public education program. In addition, special problems arise from situations involving terminal illness, e.g. conflicts between lovers and relatives of people with AIDS/ARC regarding burial rights, property, wills, power of attorney, etc.
9. Accurate information about and referral to appropriate services for people with AIDS and their loved ones is essential if the system is to work as it has been designed. Individuals who are HIV-positive and asymptomatic are also in need of assistance and referral information to help them select a doctor, counselor, or other provider, become knowledgeable about treatment options, and to make decisions about employment and insurance issues. Information and referral services typically utilize a telephone system to answer questions about AIDS in general and provide referrals to specific services as needed.
10. "Case management" refers to a wide range of support functions, the key elements of which include: (a) assessing the needs of patients/clients for health care and support services, (b) a goal of maximum independence of the client, (c) multidisciplinary determination of whether a client should be case managed and by whom, (d) direct services to a client when appropriate rather than brokering all services, and (e) ensuring patient/client access to services needed. All of the elements of services mentioned above and in other sections of this report provide some features of case management. As San Francisco's continuum is currently organized, each provider typically takes responsibility for certain case management functions while the patient/client is involved with the organization. When the patient/client moves on to another service organization, case management responsibilities are assumed by the next organization. It is anticipated, however, that in the near future a more centralized, comprehensive service will be piloted, under which a single case manager will be assigned to a patient at the time of first admission to an acute or intermediate care facility.

#### D. CURRENT SERVICES

##### Subacute and Skilled Nursing Services

Garden Sullivan Hospital provides subacute hospital care for San Franciscans with AIDS and severe ARC within its 10-bed Garden Unit, which is



licensed to provide acute rehabilitation services. Most patients are admitted from acute care hospitals. Common causes for placement at GSH are acute diarrhea, dementia, dehydration, and other sudden losses of function that require 24-hour care. A contract with DPH provides for six patients per day, three in the skilled nursing unit and three in the Garden Unit. Additional AIDS patients are covered by private insurance.

A gender and racial/ethnic breakdown of the 86 AIDS/ARC patients serviced in 1986-87 is not available.

### Housing

Shanti Project secures and manages low-cost, long-term housing for single men, women, and emancipated minors with AIDS or severe ARC (generally understood to mean a prognosis of six months or less) who have been displaced. Each resident is provided with a separate room; kitchen, living room, and bathroom are shared. The aim of the program is to provide a home, not simply a shelter, for persons with AIDS/ARC facing debilitation and death. The program promotes cooperative interaction, emotional stability, and the independence and control of residents over their environment. Program staff screen prospective residents, determine eligibility, help with moving, facilitate house meetings, provide advocacy for residents needing related support services, and generally maintain the premises. Staff do not live-in or provide meals. While Shanti itself does not provide licensed home health care services, these residences are settings in which licensed home health care can be provided in a responsive and supportive environment. Volunteers from Shanti's Practical Support Program and Emotional Support Program also work with residents from a separate administrative base.

A typical Shanti residence houses four people. The program's current capacity is 48. It is estimated that 120 individuals will be housed by this program in 1987-88. Length of stay ranges from a few weeks to more than a year and averages 240 days. Causes of termination of residence are: 90% because of client deaths, 9% at the initiative of clients, and 1% at the initiative of program staff.

Based on 1986-87 experience, it is expected that of the 120 clients anticipated in 1987-88, 25.8% will be from racial/ethnic minority groups and 3.3% will be women.

Some people with AIDS or ARC have been excluded from the housing programs described above due to active substance abuse or severe psychiatric problems. Community Substance Abuse Services (CSAS) recently received funding to contract for a 21-bed residential treatment program for persons with AIDS/ARC and concurrent substance abuse or mental health problems. Baker Places, Inc., was selected as the contractor for these services, and the residence accepted its first client in October 1987. This CSAS program is discussed further in the section on substance abuse services.



DPH's Medically Indigent Adult (MIA) Program has contracted with Catholic Charities to develop a hotel-based residential program with 24-hour, on-site social support services. The AIDS/ARC Residential Program targets homeless people with AIDS and ARC who have been unable to maintain stable housing and who have been excluded from other programs. Many of the residents have substance abuse and/or mental health problems. The program, which began operation in March 1987, has been plagued with difficulties emanating from the management of the 40-room hotel secured through the Department of Social Services' homeless program. These difficulties resulted in a nearly 5-month hiatus, during which new admissions were effectively halted. The program resumed operation on November 1, 1987, with the cooperation of new hotel management. The current site will continue as the temporary location of the program while Catholic Charities completes negotiations on a new facility that will become the permanent home for the program. Catholic Charities recently received a \$2 million Federal grant under the Stewart B. McKinney Homeless Assistance Act to provide Section 8 rent subsidy vouchers for up to 35 residents over a 10-year period. Home health care is available to residents under the general contract with Hospice of San Francisco and under arrangements with DPH's Central Aid Station and Health Care for the Homeless Program.

Of the 17 people living in the program prior to its temporary interruption, five were ethnic minorities and three were women.

It seems fairly well documented that there are at least 200 persons with AIDS or ARC in San Francisco who do not have adequate housing. Some have estimated as many as 400. If currently funded AIDS/ARC housing programs were operating at capacity, approximately 100 of these could be accommodated. Those among this population of people with AIDS and ARC not adequately accommodated are often housed informally in shelters and Single Room Occupancy (SRO) hotels. At recent count, approximately 50 people with AIDS and ARC had been referred by community agencies to a half-dozen central-city SRO hotels managed by sympathetic and receptive hotel operators. However, people staying in shelters and even SRO hotels often lack access to the kind of support and advocacy services provided by Catholic Charities (see above). At best, they are environments which make health management difficult.

The City's homeless program typically provides 3-day and 2-week vouchers for roughly 2,000 rooms in SRO hotels, and overnight stays for about 500 people in four City-funded shelters. It is important to be clear that the number of beds in the homeless program reflects total capacity, not the number of people with AIDS and ARC; in fact, the actual number of people with AIDS and ARC who use the homeless program may vary greatly from one point in time to another, and their presence is not always known to program staff.

The San Francisco AIDS Foundation's Emergency Housing Program provides housing for persons with AIDS or ARC in a program-managed facility for up to six weeks (typically three), limited hotel accommodations for up to two weeks (typically one), and help in obtaining public assistance and in developing alternative permanent housing resources. At this time the program is unable

to serve the needs of children, people whose mobility is grossly impaired, or clients with major medical and/or psychological disorders which prohibit their utilization of independent living skills. A significant portion of the clients are chronic substance abusers and are therefore not eligible for many existing housing and support programs. The program houses up to eight individuals at a time in its own flat and provides others with Foundation-subsidized hotel vouchers. Program staff also facilitate the placement of an average of 25 clients per month in other hotels and through roommate referrals.

Based on 1986-87 experience, it is expected that, of the 144 clients actually housed at Foundation expense (distinct from those whose access to other housing resources is facilitated by Foundation staff) in 1987-88, 26.4% will be from racial/ethnic minority groups and 3.8% will be women.

Most babies born to drug addicted mothers in San Francisco are sent home with their parents, while a small percentage are ordered by the court to foster care. Those who are in need of foster care and are also sick and withdrawing from their inherited addiction are placed in a special program called "Baby Moms" run by the Department of Social Services. These infants are obviously at high risk for HIV infection. This unique program for fragile infants provides very specific training for foster parents on the care of the infants and offers them monthly support groups and 50 hours of respite care each month. It is anticipated that this program will have 16 specially trained foster "homes" during 1987-88, which can care for a total of 32 infants. As of December 1987, 14 high risk babies were placed in eight homes and three of them were HIV antibody positive.

### Home Health Care Services

Visiting Nurses and Hospice of San Francisco (now a subdivision of Pacific-Presbyterian Medical Center) provides a full range of home health services for persons with AIDS and severe ARC. A multidisciplinary team provides an individualized program of organized, skilled, and compassionate care utilizing pain control, comfort care, and relief of the symptoms of terminal illness, whether physical, emotional, psychological, or spiritual. An average daily census of 80 persons with AIDS and ARC has been contracted for in 1987-88. During the year about 512 patients will be served. Length of stay in the program averages 57 days. Over 80% of terminations in the program are because of death, about 15% because of remission, and the rest because of relocation.

In February 1987, Hospice of San Francisco opened a residential program (Coming Home Hospice) at which home health care is provided to residents by the AIDS home care teams described above. It is estimated that 10 of the 80 patients per day contracted for will be cared for in this environment.

Based on 1986-87 experience, it is expected that, of the 512 patients anticipated in 1987-88, 7.4% will be from racial/ethnic minority groups and 0.5% will be women.



Under existing arrangements, Public Health Nursing maintains liaison with those who are AIDS care providers and will provide in-home health and social assessments of 130 AIDS/ARC patients in FY 1987-88, followed by appropriate referrals.

#### Emotional Support, Social Support, and Advocacy

Day care services are becoming increasingly important as a resource for people with AIDS and ARC. An independent survey of hospitals in San Francisco indicated that approximately 30% of patients on acute care inpatient units could be discharged if a day care facility was available. AIDS Day Care Services Centers Inc. is a non-profit corporation specifically set up to provide attendant care, case management, emotional support, nutrition counseling, and other necessary support services that will allow people to live at home. This agency has based its model on that of senior adult day health care and has identified a location that will be licensed to serve 120 clients at any time and has developed a strategic plan for the early phases of the program. This center hopes to open in the summer of 1988, depending on available funding.

There is an ecumenical network of Bay Area agencies responding to the AIDS crisis, working together to meet the needs of individuals with AIDS/ARC and their families. The Jewish Emergency Assistance Network, for example, offers counseling and support, crisis intervention, financial assistance for emergency expenses, community education, and resource and referral services for people with AIDS or ARC, their families, loved ones, and others with AIDS-related concerns. Catholic Charities operates a pastoral information, referral, and counseling service through its AIDS Ministry for those who desire spiritual support.

Shanti Project's Practical Support Volunteer Program recruits, trains, and supervises volunteers to assist people with AIDS and severe ARC in the execution of their basic everyday needs: shopping, laundry, cooking. Volunteers from this program are also utilized by the Residence Program and San Francisco General Hospital Program on an as-needed basis when such support is necessary. Currently, individual volunteers are provided to each person requesting such support. In addition, two van drivers are employed to provide transport to non-emergency medical, psychiatric, and social service appointments. These vans operate 40 hours a week, and one of them is wheelchair equipped. Shanti estimates that 63,000 client contact hours will be provided through this program in FY 1987-88. Based on 1986-87 experience, it is expected that of the 2,979 clients anticipated in 1987-88, 15.7% will be from racial/ethnic minority groups and 1% will be women.

The AIDS Emergency Fund is an organization that operates entirely on private donations to provide emergency financial assistance to people with AIDS and just recently to people with disabling ARC. Individuals who have an income of less than \$700 per month, and a physician's diagnosis of AIDS or



severe ARC qualify for services under this program. The AIDS Emergency Fund will pay for such things as utility and phone bills, rent, and medications. The program helps an average of 130 people a month disbursing an average of \$32,000 every month. It is anticipated that the addition of disabling ARC as a qualifying diagnosis will increase the number of people who receive assistance during the latter part of 1988, however it is not possible to predict how much of an increase there will be.

Catholic Charities operates an Emergency Health Fund that offers financial assistance to help pay for medical bills for anyone with an AIDS or ARC diagnosis or any life threatening illness, whose income is \$700 a month or less. More than \$150,000 in medically related financial assistance to more than 500 people with AIDS and ARC has been distributed since its inception in 1986.

The Family Link is a nonprofit organization established for the primary purpose of providing affordable accommodations in a safe, supportive environment for families and loved ones visiting people in San Francisco who have AIDS. This group was established in 1985 as the need to provide supportive hospitality to families and friends of AIDS patients became increasingly apparent. The Family Link can accommodate people in eight guestrooms with shared kitchen and living room facilities. There are two resident managers who work full time to maintain the guest accommodations, handle administrative tasks, seek funding for continued operations, and provide local transportation for guests as necessary. During FY 1986-87 the program accommodated 7,586 guests. This program also receives no government grants.

The Food Bank Program of the San Francisco AIDS Foundation is a community-supported program which assists indigent people with AIDS or ARC through grocery supplementation. The average income for a person with AIDS using the Food Bank is \$533 per month; the average income for a person with ARC is \$301 per month plus \$20 in food stamps. The Food Bank provides up to one bag per week of groceries to each client and expects to distribute 7,388 bags in FY 1987-88. Based on 1986-87 experience, it is expected that of the 656 clients anticipated in 1987-88, 20.6% will be from racial/ethnic minority groups.

Reimbursements from the Department of Social Services for in-home supportive services are generally handled through Hospice of San Francisco's AIDS Home Care program.

Several community-based meal delivery programs also serve persons with AIDS/ARC. The largest of these is Open Hand, which anticipates 127,000 deliveries in 1987-88. Each delivery includes two meals. Open Hand is entirely supported by private contributions.

Emotional support services are an integral part of the continuum needed to maintain people with AIDS/ARC outside of acute care settings. They are discussed in more detail in the sections on Mental Health Services and

Substance Abuse Services. Mental health programs include a peer counseling program managed by Shanti Project, a counseling and advocacy program at SFGH also managed by Shanti Project, mental health assessments and educational support groups offered by the UCSF AIDS Health Project, and Pacific Presbyterian Medical Center's Operation Concern, as well as individual and group counseling offered by Community Mental Health Services. Substance abuse contract programs administered by Community Substance Abuse Services include a variety of group and individual counseling services.

The San Francisco AIDS Foundation's Client Services Department provides client advocacy and assistance for those not yet or not currently connected to organized health care services. Services include (1) information and referrals on entitlements and eligibility; (2) orientation to, scheduling, and trouble-shooting for General Assistance, Food Stamps, MediCal, Social Security, and other entitlement programs; (3) case management of clients with multiple service needs; (4) liaison with hospitals and community agencies to reach target populations; (5) technical assistance for and training of other direct service providers; and (6) limited development of employment and other resources for clients. The staff of this program is bilingual (Spanish) and multicultural. To facilitate access of some people with AIDS/ARC (particularly prospective clients from ethnic minority groups) to these services, Foundation-based social workers are available from time to time to work with clients at sites other than the Foundation's offices. It is expected that in 1987-88 at least one AIDS Foundation social worker will be spending a portion of each week at the Instituto de la Raza, working with Spanish-speaking AIDS/ARC clients who have an established relationship with other services at the Instituto. It is also expected that the Foundation will be considering an expansion of this "satellite office" concept to other community-based settings as the year progresses.

In FY 1987-88 the Foundation's social service advocacy program is expected to serve 1,600 persons with AIDS/ARC in San Francisco, 21% of whom will be from racial/ethnic minority groups and 3% of whom will be women.

Although it is not a typical emotional support program, the national NAMES Project has provided a positive and creative means of expression for those whose lives have been touched by the epidemic. This quilt, created in homes across America, represents the great diversity of people and backgrounds and illustrates the impact of the AIDS epidemic by showing the humanity behind the statistics. It is the hope of the NAMES Project that over the duration of the epidemic, the Project will be an ever-expanding symbol of the dignity and strength of those who grieve the loss of a loved one to AIDS. Funds raised from donations and special events remain in the host communities to support direct services to people with AIDS and their loved ones.

In San Francisco two community organizations provide legal education on AIDS-related issues and free or reduced-cost legal services to persons with AIDS/ARC and their significant others: the Bay Area Lawyers for Individual Freedom (BALIF) and National Gay Rights Advocates (NGRA). Their education efforts focus on wills, testing, confidentiality, employment, insurance, and



housing discrimination. Their legal services address similar issues, as well as probate, bankruptcy, etc. NGRA is also active in promoting legislative and administrative policy initiatives to protect and better serve people with HIV-related concerns.

BALIF expects its AIDS Legal Referral Panel to serve 1,500 persons with AIDS/ARC in the Bay Area in 1987-88, 75% of whom will be San Francisco residents and 17.6% of whom will be from racial/ethnic minority groups.

The San Francisco Human Rights Commission (HRC) is the administrative agency primarily responsible for the enforcement of Article 38 of the Municipal (Police) Code, the AIDS/ARC Discrimination Ordinance. Under this ordinance the Commission has conducted a public outreach campaign and the investigation, mediation, and resolution of complaints of AIDS/ARC-based discrimination. In FY 1986-87, the Commission investigated more than 58 AIDS/ARC-related complaints, a slight decrease over the previous year and the first decline since AIDS complaints began to be recorded in 1982. While the AIDS Discrimination Ordinance passed by San Francisco in 1985 has had an impact on complaints, AIDS-based discrimination continues to be a significant problem. The actual number of reported instances of discrimination is approximately three to four times the number of investigated complaints.

In addition to assistance to individuals, the Commission provides technical assistance to City agencies, other governmental bodies, community groups, the private sector, and the media. The Commission has played a role in the development of services for underserved populations, specifically women and racial and ethnic minorities. As the population of people with AIDS/ARC continues to shift toward these populations, the Commission has assumed an increasingly active role in the area of housing.

In FY 1987-88 the Human Rights Commission staff is expected to serve 83 persons with AIDS/ARC in San Francisco, 40% of whom will be from racial/ethnic minority groups and 20% of whom will be women.

In the latter part of FY 1987-88 HRC staff have agreed to expand their role in working with persons with AIDS/ARC to include investigating complaints filed by clients or prospective clients of AIDS service providers. They will, in other words, play a more active role in assessing providers' compliance with Departmental policy and contract requirements.

#### Case Management Services

Information and referral about the continuum of support services for persons with AIDS/ARC is provided to some degree by all agencies working with the epidemic, particularly those providing some case management services. In addition, there is a special information and referral focus at the San Francisco AIDS Foundation and Shanti Project. The Foundation's AIDS Hotline is complemented by a special contact number answered exclusively by volunteers who themselves have AIDS; the information and referral functions of the



Foundation's Social Service Department are discussed above. Shanti Project also handles a large number of requests for information and referrals.

If the application for funding of a San Francisco case management project proposal is approved by DHS, the role of Public Health Nursing will be expanded considerably during the latter half of 1987-88. The proposal provides for a pilot program comprised of two case management teams, each following 40 AIDS/ARC patients from the time of their initial admission to an acute or subacute facility through the balance of their experience with HIV-related disease. Each team will be directed by a public health nurse and will include a medical social worker and some clerical support. The team will be responsible for ongoing assessment of patient/client needs and ensuring access to appropriate services. DPH considers the model particularly appropriate for situations in which patients and their personal support systems are less willing or able to take the steps necessary to initiate access to needed services (e.g. situations involving neurological impairment or concurrent substance abuse).

DHS has required that 25% of the patients served by the pilot project be from racial and ethnic minority groups.

Catholic Charities has casemanagers who assist clients that participate in their direct service programs. These casemanagers assist clients by locating and delivering the help clients need from community resources and government agencies that furnish the kinds of services and benefits that are commonly required by people with AIDS or ARC.

#### D. FACTORS INFLUENCING THE DEVELOPMENT OF CHRONIC CARE, HOUSING, AND RELATED SUPPORT SERVICES

##### General observations

1. Although the seroconversion rate among gay/bisexual men in San Francisco has dropped to less than 4% per year and there is some evidence that the seroconversion rate among IV drug users in San Francisco is approximately 3% per year, the number already infected by HIV is large.
2. AIDS is currently most evident in population groups whose home support systems are (a) in some instances strong but non-traditional (and with whom some may therefore find it awkward to work), (b) in some cases weak (e.g. roommates who may not be willing or able to take on the role of primary care provider when in-home hospice services are required) and (c) in many cases non-existent (e.g. some have never had a home support system; others have been abandoned). This will continue to have a significant impact on the organization of community-based responses to the epidemic.

## Service delivery issues

3. The array of AIDS prevention services in San Francisco has expanded in proportion to the growth of the epidemic in the city. Community-based agencies have typically prioritized the need for communication and cooperation with one another, resulting in little, if any, duplication of services. Nonetheless, the sheer number of available programs can be overwhelming for an individual with AIDS, ARC, or HIV infection who is assessing available resources. As services diversify it may become increasingly important to establish a central information and referral clearinghouse to increase access to services.
4. The physical and economic devastation of AIDS, combined with fear and discrimination, have been major contributing factors to homelessness among people with AIDS and ARC. However, as the incidence of AIDS increases among substance abusers and others already living on the margin, the demand for supported housing is expected to grow even more substantially. The capacity of DPH to respond to this demand will depend very much upon a policy clarification as to which City department has the primary responsibility and resources to develop additional housing affordable to people receiving public assistance.
5. Although the distribution of cases among population groups requiring treatment is not expected to change significantly, the actual numbers in currently low-incidence groups are expected to increase dramatically. The preponderance of current cases of both AIDS and ARC is among white gay and bisexual men. The majority of reported cases with a history of IV drug use are also white gay and bisexual men. While DPH anticipates that in the next five years most new cases of CDC-defined AIDS will also be from these groups, the incidence of AIDS among (a) members of racial and ethnic minority groups (both gay/bisexual and non-gay/bisexual), (b) women, (c) non-gay/bisexual substance abusers, and (d) jail inmates may require new service configurations or modifications of existing service delivery systems.
6. As more adults with dependent children are diagnosed, there will be a growing need for appropriate care for families and children.
7. As more children are diagnosed with AIDS or develop HIV-related infections, special support services for parents and foster parents may need to be developed.
8. The California Department of Health Services (DHS) has commissioned two studies of the need for special health care and psychosocial support in racial and ethnic minority communities. In San Francisco the studies are being conducted by the Instituto Familiar de la Raza in Latino communities and by Westside Community Mental



Health Center in Black communities. Neither study is scheduled for completion before June 1988. These may have implications for planning future primary care as well as chronic care and related support services in San Francisco.

Support service issues

9. There are new patterns in the clinical manifestations of AIDS. The marked increase in the incidence of neurological impairment is the most dramatic example. These new patterns will require different treatments and different support services.
10. The vast majority of those who develop AIDS or severe ARC are members of behavioral minorities (gay men and IV drug users) whose behavior is, in the minds of many, presumed to be reprehensible. People with AIDS/ARC are often blamed for their condition. Patients often incorporate this sense of guilt. This complicates the task of psychosocial support services.
11. AIDS is an infectious disease and, unlike most chronic illnesses, can be transmitted from one person to another. Even though epidemiologists are in general agreement that the virus is very difficult to transmit, many fear contagion from casual contact. Reactions to people with AIDS/ARC often amount to hysteria. This hysteria has created particular problems in health care and employment settings, as well as with families and friends and in living situations.

Treatment and care issues

12. New treatments are being developed. New drugs will prolong life expectancy and therefore expand demands for health care services. New treatment regimens may create demands for different staffing, space, and equipment, primarily in outpatient service settings. Although the anticipated impact of AZT has been factored into current projections of service needs, the impact of other possible therapies has not.
13. Patients with certain clinical manifestations of ARC sometimes require as much care and support as patients with AIDS, yet they are not presumptively eligible for MediCal, SSI, etc. This tends to make them more dependent on local public resources. The expanded definition of clinical AIDS recently issued by the Centers for Disease Control (September 1987) has reduced the proportion of those disabled by HIV disease who are not formally classified as having AIDS. However, some will still fall into this category of severe ARC not presumptively eligible for MediCal, SSI, etc.
14. Post acute care beds for persons with AIDS/ARC are currently quite limited. DPH currently contracts for six beds per day at Garden



Sullivan Hospital. Under a special arrangement which combines the services of a licensed board and care facility with those of a licensed home care program, Coming Home Hospice reserves 10 beds per day for AIDS patients. Ralph K. Davies Medical Center recently offered to provide skilled nursing care for AIDS patients at the MediCal rate of \$152 per day. It is not yet clear how many beds per day this will mean or how long the service will be provided, given that the actual cost will be significantly greater than \$152 per day.

#### Funding issues

15. The California Department of Health Services (DHS) has identified funding for a direct contract to a skilled nursing facility (SNF) in the San Francisco area to cover SNF care for 10 persons with AIDS/ARC. The ostensible purpose of the project is to develop a pilot program through which MediCal can establish appropriate staffing/service configurations and real costs associated with this level of care for persons with AIDS/ARC. A formal Request for Proposals (RFP) has been reissued three times for this demonstration project but no providers based in San Francisco have gone beyond the discussion stage with DHS. It is apparent that DHS' expectations of prospective providers are viewed as untenable.
16. DPH has proposed to the Federal government that the Public Health Service Hospital on Lake Street, which was decommissioned in 1978 and subsequently used by the U.S. Army for a language school, be reopened as a regional facility for post acute care for persons with AIDS/ARC. Legislation which authorizes leasing the building to DPH for one dollar a year for an AIDS program passed both the House and Senate in September. Companion legislation needed to address the costs of remodeling the building and subsequent operations remains in committee.
17. Some people with AIDS/ARC may live long enough to qualify for Medicare; Medicare regulations may be revised to shorten the period between diagnosis and eligibility. Proposed extension of Medicare coverage for catastrophic illnesses should include eligible AIDS patients.
18. The California Department of Health Services (DHS) has applied to the U.S. Department of Health and Human Services' (DHHS') Health Care Financing Administration (HCFA) for a "Medicaid waiver" to provide home- and community-based services to eligible MediCal recipients with AIDS or ARC. HCFA's approval of the application will, in essence, entitle MediCal to provide fee-for-service reimbursements for out-of-hospital services not previously covered by MediCal. HCFA regards such waivers as demonstration projects which must, within three years, demonstrate that these services

provide a cost-effective alternative to the hospital-based care that would otherwise be required. The waiver is expected to be in effect by July 1988. Similar waivers have already been approved by HCFA for New Jersey and New Mexico.

19. In anticipation of the MediCal waiver, DHS has issued an RFP for AIDS case management and home/community-based care. DPH has proposed using these funds to (a) initiate a centralized case management program which DHS will require of communities benefiting from the MediCal waiver, (b) develop accounting and billing procedures of the community-based providers of waived services, and (c) underwrite some direct costs of subacute and skilled nursing care.
20. It is apparent that DHS intends to use the centralized case managers discussed above to restrict access to home- and community-based services in ways which may be inconsistent with current practices in San Francisco. The costs of some of these services are to be reimbursed by MediCal under the waiver being requested of the DHHS Health Care Financing Administration and the case managers are expected to limit costs to pre-established caps.
21. It seems equally likely that by 1989-90 at least DHS hopes to discontinue or phase out grant support of home- and community-based services (which DPH currently receives for its AIDS Home Support Project) in favor of fee-for-service reimbursements under the proposed MediCal waiver.
22. DPH has received a demonstration project grant from the U.S. Public Health Service's Health Resources and Services Administration (HRSA), which provides funding to underwrite a variety of chronic care and other support services over a 27-month period beginning July 1987: home care (5 patients/day), in-home medical assessments (physician and psychiatrist time), residential substance abuse treatment for persons with AIDS/ARC (21 beds/day) and intermediate care (6 beds/day beginning January 1988).
23. It is not clear how Federal agencies will contribute to chronic care and related support services for persons with AIDS after 1989, when current funding for demonstration projects is scheduled to end. Congress has become increasingly interested in the epidemic and seems disposed to make larger appropriations. However, the highest levels of the present Administration seem preoccupied with testing rather than prevention or cost effective health care. It appears unlikely that the President's Commission on AIDS will break this pattern. In addition, there seems to be sentiment in Washington to give funding to State governments in block form and rely on State agencies to oversee the funding of local programs. Such an administrative arrangement would effectively counteract much of the benefit of new Federal funding for AIDS health care services.



24. DPH anticipates a general increase in dependence on public-sector support. Patients will live longer, and more will "spend down" to eligibility for greater public assistance.
25. Gay men and IV drug users are minorities who often choose not to share information about their lifestyles. When AIDS or ARC is diagnosed, many are obliged to admit to family, friends, and colleagues for the first time that they are members of one of these risk groups. In such situations, patients and those who comprise their personal networks must often deal simultaneously with the news of a terminal illness as well as a hidden lifestyle. This will continue to have a significant impact on the need for psychosocial support services available to persons with AIDS/ARC.

#### E. POLICY REAFFIRMATION

1. DPH will maintain its general focus on comprehensive chronic care, housing, and related support services to maximize patients' potential to maintain themselves at home or in residential facilities.
2. DPH will ensure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, race/ethnicity, culture, language, and gender shall be evident in all service configurations.
3. Service utilization assessments, quality assurance, and cost analyses of various service configurations will be ongoing to ensure that in the long run services provided are indeed the most appropriate from the perspective of both health care and cost.
4. DPH acknowledges the importance of support services for persons with AIDS and ARC which are now entirely funded by private donations, services such as the grocery supplement and meal delivery programs described in this chapter. DPH reaffirms its commitment to encouraging State and Federal agencies to support such programs. DPH will seek to identify categorical grant funding that would be appropriate for such services and is prepared to act as the fiscal agent for community-based providers in situations where such a fiscal agent is required.



## XII. MENTAL HEALTH SERVICES

### A. GOALS

A general goal of mental health services is to help clients manage more effectively the ordinary stresses of daily living as well as cope with the extraordinary pressures associated with personal and community crises. These services, in large measure educational and psychotherapeutic, address a variety of issues with different strategies that depend on an individual's relationship to the epidemic. In general terms, the populations that might call on mental health services to help cope with the stresses related to AIDS fall into one or more of the following categories:

- (a) people who have developed clinical manifestations of advanced HIV infection and who face the prospect of chronic illness or death;
- (b) people who know they have been infected with HIV but remain asymptomatic and who are concerned about the prospect of developing clinical disease or transmitting the infection to others;
- (c) people in groups at high risk who are concerned about being or becoming infected;
- (d) people who have friends, lovers, or relatives diagnosed with or at risk for AIDS and who must share the burden and consequences of that diagnosis;
- (e) people who are anticipating or grieving the death of a loved one from AIDS;
- (f) people whose professional activities bring them in contact with any of the above;
- (g) people who, whether they have been personally affected by AIDS or not, are having to deal with the a sense of community decimation.

In addition, there is mounting evidence that neuropsychiatric disease results from opportunistic infections, neoplasms, and central nervous system complications associated with HIV infection. Clinical reports indicate that 30% to 75% of individuals with AIDS infection experience some form of cognitive impairment that affects their ability to function and may oblige them to seek mental health services. Dementia may range from mild to disabling cognitive or motor dysfunction, insidious depression characterized by apathy and withdrawal, to acute psychotic presentations with delusions, hallucinations, and psychomotor agitation. Another goal of DPH's mental health programs, therefore, is to provide appropriate and high-quality medical and psychiatric care for those individuals with dementia or other neurologic complications associated with HIV infection.

## B. ELEMENTS OF SERVICE

As with health education and substance abuse services, the elements of mental health service may be categorized in a variety of ways which do not result in mutually exclusive groups. Services are sometimes grouped in the following ways:

- (a) Services defined by the acuity of problems they address: emergency and crisis, acute, subacute, transition, etc.
- (b) Services defined by the type of provider response: assessments, medication, psychotherapy, counseling, referral, etc.
- (c) Services defined by focus of activity: crisis resolution, insight, behavior change, psychosocial support, etc.
- (d) Services defined by modality: inpatient and locked facility, outpatient, day treatment, residential, etc.
- (e) Services defined by the community targeted: groups defined by their age, gender, race or ethnicity, sexuality or sexual orientation, neighborhood, etc.

For purposes of this report, the description of AIDS-related mental health services will be organized by age-focused categories. These are categories into which Community Mental Health Services (CMHS), provided directly or contracted to the Department of Public Health (DPH), are typically grouped. Most of the data available about DPH service capacities and budgets are available under these headings. It is important to recognize, however, that some of the providers of services described may regard a different taxonomy as being more indicative of their emphasis and primary concerns.

- 1. Information and Advocacy Services
- 2. Adult Community Services
- 3. Adult Acute Care Services
- 4. Children's, Adolescents', and Family Services
- 5. Geriatric Services

There are only a few government-supported programs funded specifically to provide mental health services to people with AIDS/ARC or to address AIDS-related issues. However, the majority of the 116 programs associated with CMHS are involved in one way or another with AIDS-related concerns. The overview presented here should help readers (a) understand the framework within which mental health services for people with AIDS is developing and (b) assess the impact of the AIDS epidemic on the existing mental health system.



The training of staff members who deal with mental health issues associated with HIV infection is addressed in the chapter devoted to Provider Education and Staff Support. Some highlights specific to mental health will be noted below.

### C. CURRENT SERVICES

An overview of the five categories of service provided by DPH's Community Mental Health Services (CMHS) follows. AIDS-specific programs offered by contractors of DPH's AIDS Office are described within the category with which each is most closely associated.

#### Information and Advocacy Services

The San Francisco AIDS Foundation's AIDS Hotline is the most widely advertised source of information and referral about AIDS-related services. Where mental health issues are concerned, the AIDS Health Project of the University of California at San Francisco provides more specialized referrals and advocacy; its services are described more fully under Adult Community Services. Shanti Project also provides telephone counseling and referrals under the aegis of a privately funded program for persons with AIDS/ARC, their lovers, families, and friends.

Other information and advocacy programs of DPH's Community Mental Health Services provide information and advocacy that is generic to mental health concerns rather than AIDS-specific.

#### Adult Community Services

Programs included under adult community services are outpatient, day treatment, and case management. Adult outpatient services are designed to provide short-term or sustained therapeutic intervention for individuals experiencing acute and/or ongoing psychiatric distress. They include crisis intervention and assessments; individual, group, and family therapy; medications; home visits; and case management. Day treatment services are designed to provide alternatives to inpatient care and/or supplement residential service and other modes of treatment. The purpose of case management is to identify individuals in need, track and monitor progress and movement within the system, and intervene as needed to assure the availability and adequacy of treatment and necessary social services.

It is anticipated that approximately 800 clients with HIV infection or AIDS/ARC will receive outpatient and case management services from CMHS providers in 1987-88, and approximately 55 people with AIDS/ARC will be in day treatment. AIDS and AIDS-related services make up about 5% to 10% of all Adult Community Services contacts.



All 31 programs in this category (serving 12,739 individuals) report some staff and client activity related to AIDS. These include AIDS awareness, education, and prevention activities; support groups for clients with AIDS/ARC or the "worried well"; family members and significant others of people with AIDS/ARC; crisis intervention; brief and ongoing psychotherapy; and case management. Case management has been particularly important for clients whose AIDS/ARC or HIV-positive status is secondary to a primary mental health disorder. These patients typically are low-functioning prior to their HIV infection, and therefore once they become ill they are even less capable of caring for themselves, making case management difficult.

Since 97% of the reported AIDS cases in San Francisco are among gay and bisexual men, it is not unusual that AIDS/ARC and HIV-related mental health services are to be found in clinics in neighborhoods with a high concentration of single men. For example, the outpatient mental health clinic at District Health Center #1, located in the Castro, is integrally linked to screening and primary care of those in the neighborhood who are at risk for or diagnosed with AIDS/ARC. The outpatient program, managed by Operation Concern with support from CMHS, reports that 30% of its clients are diagnosed with AIDS/ARC and that most of the remaining 70% are dealing with AIDS issues of sero-status, risk reduction, and coping with lovers, friends, and relatives with AIDS. It must be noted, however, that these clinic services were established before AIDS became epidemic. Their focus and activities have been adapted to accommodate the demands of the epidemic, and there has been a corresponding need to cut back other mental health services.

In 1987-88 CMHS allocated City/County funds specifically to underwrite in-home services to AIDS/ARC clients and their families who for medical, socio-cultural, and/or psychological reasons are unable to come to outpatient clinics. Identification of a prospective provider has been difficult, but it is expected that services will become available toward the end of FY 1988. They will be linked with primary mental health care settings.

Under contract with DPH's AIDS Office, the University of California at San Francisco's AIDS Health Project (UCSF/AHP) currently provides a range of mental health services based in Ward 86, the AIDS/ARC outpatient clinic at San Francisco General Hospital. A full-time AHP psychotherapist has an established consultative role within the clinic and functions as a member of the treatment team. Clients are seen as a result of either self- or staff-generated referral for assessment and evaluation because of acute psychological or emotional distress, behavioral disturbance, or interest in group work (for stress reduction or couples) offered by AHP. The focus of these groups is to help individuals deal more effectively with the disease. The services offered in this setting include crisis intervention, psychological assessments, patient-centered consultation with medical staff, group interventions, short-term psychotherapy services (not to exceed 12 weekly sessions for more than six clients at any time), and referral to other resources.

This AHP program at Ward 86 also provides psychiatric outreach to support the care of neurologically impaired patients in their homes. Patients

in need of evaluation are identified by current home care personnel. The .25 FTE psychiatrist attends weekly patient care conferences to discuss patients' needs at the Hospice of San Francisco and the Shanti Residence program. The psychiatrist also attends discharge planning meetings at SFGH to assess whether patients being discharged to the home-care system may require psychiatric management.

Although based at SFGH, neither of the AHP services described above is restricted to patients at SFGH. More than 300 clients are expected to average seven contact hours each in this program in FY 1987-88.

Included in the contract between the UCSF AIDS Health Project and DPH's AIDS Office are provisions for a second AHP program, under which the Project organizes and supports therapists in private practice willing to provide free or very low-cost therapy for a limited number of hours per week for people with AIDS/ARC and others with AIDS-related concerns. Federal funding administered by the AIDS Office provides AHP with a half-time staff member to (a) recruit and coordinate these volunteer services, (b) facilitate the development of a support system for them (e.g. regular in-service training opportunities), and (c) screen and refer prospective clients as appropriate. This program projects 380 referrals in FY 1987-88.

Other programs of the UCSF AIDS Health Project complement these mental health services. They are described more fully in the chapters on Public Education, Provider Education and Staff Support, and Substance Abuse Services.

Also under contract with DPH's AIDS Office, the Emotional Support Program of Shanti Project trains community volunteers to provide free peer counseling services to people with AIDS/severe ARC who are confronting a life-threatening illness. Services are also available to significant others who are supporting loved ones with AIDS and anticipating or responding to the loss of someone to AIDS. Currently, individual counselors are offered to each person requesting such support, and services are provided for as long as the client and counselor find it useful. Group counseling is available for those who prefer group support. Matches are made within 48 hours of an eligible client's request. Shanti estimates that they will have a corps of approximately 400 active volunteers by June 1988 and that more than 2,329 people with AIDS/ARC, lovers, friends, and family members will be provided 127,000 contact hours of service in FY 1987-88. Approximately 5% of the total clients will be women, and 17% will be from racial and ethnic minority groups.

In a separate program, Shanti Project also provides staff counselors to meet the psychosocial needs of patients and their loved ones on Unit 5A, the AIDS-dedicated inpatient unit at SFGH. These counselors are available to AIDS patients, visitors, and hospital staff in other areas of the hospital as well on an as-needed basis. They provide crisis counseling in such situations as a patient's removal from life-support systems, potential suicide, worsening of a condition which may necessitate transfer to a Critical Care Unit, and death. They also provide patient advocacy services to optimize patient input regarding care and management.



On Ward 86 Shanti counselors are available to provide emotional support, coordination with services offered on Unit 5A, community-based anticipatory grief and bereavement support groups, and referral to community services for people newly diagnosed with AIDS. This referral program is unique in that it identifies services in the community that are sensitive to the special concerns of people with AIDS. In 1987-88 it is anticipated that the Shanti counselors will work with 630 inpatients at SFGH and 1,460 significant others. It is also anticipated that they will work with 1,610 patients at Ward 86 and 390 significant others. Based on 1986-87 experience, Shanti expects that 5% of the patients will be women and 25% will be from racial and ethnic minority groups.

#### Adult Acute Care Services

CMHS-supported adult acute care services include psychiatric emergency services and inpatient services, as well as most residential treatment services.

Two emergency programs are funded by CMHS, one at San Francisco General Hospital and the community crisis clinic at Mt. Zion Hospital. Both programs provide crisis treatment 24 hours a day, 7 days a week to individuals experiencing an acute psychiatric episode or situational crisis. Twenty-four-hour capacity for prescribing and supervising medication is available for patients requiring this level of care. The two programs expect to see approximately 12-14 different clients with AIDS-related issues each week.

CMHS-funded psychiatric inpatient services are provided at San Francisco General Hospital, St. Francis, and St. Mary's Hospital. St. Francis and St. Mary's report that HIV-related cases in 1986-87 were a small but consistent portion of their total psychiatric inpatient census. Both hospitals project that approximately 5% of the total number of psychiatric inpatients will have AIDS/ARC or HIV infection, representing approximately 7-12 patients per year.

Both St. Francis and St. Mary's offer related outpatient services to AIDS/ARC patients and bereavement support to partners of people with AIDS. Referrals are made to community services as appropriate.

AIDS/ARC patients in need of acute psychiatric care at San Francisco General Hospital are generally seen on the dedicated psychiatric unit, Ward 7B. Admissions for psychiatric hospitalizations for AIDS/ARC and HIV-positive patients have shown a steady increase over the past few years. In 1985-86 AIDS/ARC admissions totalled 15. In 1986-87 this number increased to 35 patients. In 1987-88 approximately 74 psychiatric inpatient admissions of persons with AIDS/ARC or HIV-infection are anticipated, and it is expected they will require 1,116 patient days of care.

The duration of stay for these patients is diagnosis-related. The experience of SFGH indicates that a patient with depression may stay one week,



one with dementia a month or more, and those with mixed diagnosis stay an average of three weeks. Staff at SFGH report trends of fewer patients being admitted for depression and an increase in admissions for dementia and, more recently, of patients with concurrent substance abuse. In short, the trend seems to be towards longer periods of hospitalization per patient.

Recently CMHS received a small grant from the California Department of Mental Health to establish a dedicated housing project for six persons with AIDS, ARC, and/or HIV infection who, as a result of neuropsychiatric complications, are in need of intensive supervision and assistance with daily living. CMHS is in the process of identifying a contractor for these services. This facility will have the capacity for providing all necessary non-medical care, including the provision of a safe and protective environment, assistance with personal care and hygiene, and supervision necessary for sustaining the activities of daily living. The program will provide structured social and recreational activities, psychiatric care, and case management services. Medical care will be available through other DPH clinical services or under the Department's contract for home health services for persons with AIDS/ARC.

#### Children's, Adolescents', and Family Services

Children's, Adolescents', and Family Services include programs providing crisis intervention, outpatient, day treatment, residential (3-bed facility), acute hospitalization, Golden Gate Regional Center services for the developmentally disabled not requiring a locked facility, long-term hospitalization at the locked State facility in Napa, and prevention services. In 1986-87 2,190 individuals received mental health services through this division. To date, none of the clients of this division has had AIDS or ARC and the extent of the AIDS-related services is limited. CMHS service agencies provide consultation on an as-needed basis for schools around issues of children with AIDS. Education and training programs are being developed for staff and patients (especially adolescents) in the various treatment settings.

#### Geriatric Services

Geriatric services include outpatient, day treatment, residential, and case management programs. In 1986-87 1,438 clients were served in this division. Although programs are not reporting that their clients are HIV-infected or have AIDS or ARC, concerns about AIDS have become increasingly important in service settings. It is anticipated that approximately 5% of group therapy time in outpatient, day treatment, and residential settings will be related to AIDS education and counseling in 1987-88. The staffs of all geriatric programs have received AIDS education and training and are encouraged to incorporate sensitivity to AIDS issues in their work. Individual and group therapy sessions are directed toward the concerns of persons with AIDS/ARC or HIV infection, their families, and significant others, and for the "worried well" as needed.

In 1985-86, the most recent fiscal period for which published data are available, about 20,000 individuals were served by CMHS' 116 programs. Approximately 45% were women, and 50% were from racial and ethnic minority groups.

#### D. FACTORS INFLUENCING THE DEVELOPMENT OF AIDS-RELATED MENTAL HEALTH SERVICES

##### General observations

1. Community Mental Health Services reports a lack of specialized services for AIDS-related client groups: people with AIDS/ARC, those at risk of infection, the families and friends of those infected or at risk, and people whose work brings them in contact with any of these groups. The lack of specialized services has not only created a demand on emergency and outpatient services but may have made traditional mental health settings less accessible to people with AIDS-related concerns. That is, providers in typical mental health programs may not feel qualified or comfortable caring for people with problems related to HIV infection. Where waiting lists are available for analysis, it is evident that the backlog is significant. As the number of people living with AIDS/ARC increases, it is anticipated that the demand for specialized supportive services will increase in proportion.
2. The results of research conducted by UCSF's Center for AIDS Prevention Services (CAPS) and that of the Department of Public Health on the neurological manifestations of HIV infection may have implications for planning future mental health services related to HIV infection. Information collected about the relationship between psychosocial factors and changes in the immune system and data regarding changes in mental status in people with AIDS over time may direct the planning of mental health services for this population.
3. Notwithstanding the reported concerns of CMHS about the impact of AIDS on its services, the recently released five-year mental health services long-term plan and action plan for 1988-89 contains few references to AIDS and ARC. This is evidence of the overwhelming demand for mental health services unrelated to AIDS, which further compounds the planning and implementation of AIDS specialized services.
4. Some mental health services may be better provided by agencies that do not have a "mental health" label. That is, people with concerns about AIDS may not be attracted to traditional mental health settings and may seek support services from providers in other health care arenas. It may be that one essential role of CMHS will



be to provide more formal consultation and assistance to community agencies whose clients are seeking counseling and other support services and are not willing to accept referrals to the "mental health system".

5. Mental health and other AIDS care providers have noted that, as approximately 4% of all San Franciscans are infected with HIV (one in 25 people), the mental health of a very broad range of the city's residents is impacted as they come to terms with both knowledge of seropositivity and/or AIDS/ARC diagnoses of colleagues and friends. For many in the community, mental health services need to provide support not only for the grief associated with losing a friend but for the sense of community decimation as well. All mental health service providers---not just the small number whose practices focus on AIDS---need to communicate and plan strategies for dealing with HIV in their practices.

#### Relationship to other services

6. While we have sometimes dealt with mental health concerns through settings and procedures labeled "education", "substance abuse", and "medical care" (because those are the labels funding was available to support), planning efforts need to keep in mind that there may be an appropriately larger role for "mental health" per se in the continuum.
7. Most publicly subsidized crisis intervention services, as well as opportunities for individual and group therapy, are provided through Community Mental Health Services (CMHS) programs and contract services. Few programs or contractors are specifically funded to work with AIDS issues. Underfunded even before the AIDS epidemic became recognized as such, most government-supported mental health programs have not been expanded in view of increased demands on the mental health service delivery system related to the AIDS epidemic. They have borne whatever share of the burden they have borne by cutting back in other areas.
8. The separation of community alcohol, drug, and mental health advisory boards results in the duplication of effort and prevents adequate planning for the development of new programs and the expansion of existing services.
9. The inadequacy of service capacities at levels of psychiatric care lower than acute inpatient and skilled nursing care contributes to an over-dependence on adult acute services. It is pointed out that several patients with AIDS, ARC, or HIV infection currently using acute mental health services could be cared for in less restrictive settings if the resources for this shift were adequately developed.



10. There are instances in which mental health issues related to AIDS seem to overlap with issues being addressed by other interests of the service continuum. In particular:
  - (a) neurological impairment associated with HIV infection is sometimes difficult to distinguish from mental health problems;
  - (b) problems of mental health often coincide with those of substance abuse;
  - (c) while "educational support programs" often address mental health concerns, people with severe mental health problems may be particularly unresponsive or inappropriately responsive to the messages of AIDS prevention;
  - (d) treatment of people with HIV infection in mental health settings is often complicated by issues of multiple diagnosis (for example, problems of adjustment to a diagnosis of a life-threatening illness and/or to the loss of physical integrity often accompanying any neurologic impairment).

#### Treatment issues

11. The incidence of neurological complications among persons with AIDS and ARC seems to be increasing. The implications for care are not yet clear.
12. Early manifestations of AIDS dementia may be subtle and insidious. This accentuates the need for extensive training of medical and mental health care providers regarding the extent of neurologic involvement with HIV infection, and the need for appropriate diagnostic testing and psychiatric referral.
13. More people have knowledge of their HIV antibody status and are developing attendant concerns (staying well, if positive; staying negative, if negative).
14. Recent epidemiologic evidence indicates that 65-100% of individuals who are HIV antibody positive will eventually develop AIDS. This information has changed the meaning of seropositivity and increased the level of anxiety about HIV antibody status. The AIDS Health Project reports that clients are clinically more distressed, with more suicidal ideation and more anxiety, helplessness, and depression. The demand for AHP eight-week support groups increased an average of 38% in 1987 over a similar period in 1986. The demand for these and similar services will certainly increase.
15. Often neither traditional acute medical care units nor psychiatric inpatient units are appropriate to care for people with psychiatric illness and concomitant HIV infection who require hospitalization.

These patients often need the medical technology and staff expertise available on a medical ward as well as the special capacities of a psychiatric ward (e.g. isolation rooms for people who need to be restrained). Most hospitals are not equipped to offer such medical/psychiatric care in one dedicated unit.

16. It is evident that HIV infection is continuing to pervade our communities and that the AIDS epidemic will impact on our health care, social, political, and economic systems for many years to come. The "staying power" of this epidemic means that mental health services must begin to incorporate knowledge and understanding of AIDS issues as a common denominator in their planning and program development.
17. The number of children and adolescents with HIV infection will increase over the next five years. The need to develop support services designed for these young people such as targeted counseling, day care, and rehabilitation will grow accordingly. In addition attention will have to be made to providing these types of care for family units and not simply the individual with the illness.
18. Accompanying the need for specialized mental health services for AIDS patients is a need to expand support services for those who assist in the care of these patients. Such support includes respite services for friends and family caring for people with AIDS at home, and emotional support for health care professionals caring for people in hospitals and extended care facilities.

#### Demographic distribution of patients

19. Although the seroconversion rate among gay/bisexual men in San Francisco has dropped to less than 4% per year, and there is some evidence that the seroconversion rate among IV drug users in San Francisco is approximately 3% per year, the number already infected by HIV is large.
20. As was mentioned in conjunction with the discussion of primary and acute medical care, chronic care, and related support services, the population groups requiring treatment are expected to change. The preponderance of current cases of both AIDS and ARC is among white gay and bisexual men. The vast majority of reported cases with a history of IV drug use are also white gay and bisexual men. While DPH anticipates that in the next 18 months most new cases of CDC-defined AIDS will be from the groups mentioned, we will probably see the beginning of an increase in the proportion of ARC cases who are (a) from members of racial and ethnic minority groups (both gay/bisexual and non-gay/bisexual), (b) women, (c) infants, (d) substance abusers (both gay/bisexual and non-gay/bisexual), and



(e) jail inmates. It should be anticipated that the demand for mental health services will shift in proportion. These populations may be better served in settings other than those in which current services are provided.

21. The California Department of Health Services (DHS) has commissioned two studies of the need for special health care and psychosocial support in racial and ethnic minority communities. In San Francisco the studies are being conducted by the Instituto Familiar de la Raza in Latino communities and by Westside Community Mental Health Center in Black communities. Neither study is scheduled for completion before June 1988. These may have implications for planning future mental health services in San Francisco. Of particular concern will be the availability of services for those who do not speak English.

#### Funding

22. Some people with AIDS/ARC may live long enough to qualify for Medicare, and/or Medicare regulations may be revised to shorten the period between diagnosis and eligibility. Whatever coverage Medicare provides for psychiatric or other mental health services may play an increased role in funding AIDS-related services.
23. Patients with certain clinical manifestations of ARC sometimes require as much care and support as patients with AIDS, yet they are not presumptively eligible for MediCal, SSI, etc. This tends to make them more dependent on local public resources. The expanded definition of clinical AIDS recently issued by the Centers for Disease Control (August 1987) has reduced the proportion of those disabled by HIV disease who are not formally classified as having AIDS. However, some will still fall into this category of severe ARC not presumptively eligible for MediCal, SSI, etc.
24. DPH anticipates a general increase in dependence on public-sector support. Patients will live longer, and more will "spend down" to eligibility for greater public assistance.
25. Federal grants for front-line mental health services related to HIV infection have been difficult to secure. To date, Federal appropriations that have been categorical to mental health have emphasized staff development rather than patient care.
26. State appropriations to local jurisdictions for AIDS-related mental health concerns have been small: \$700,000 in 1987-88, of which \$200,000 was designated for hemophiliacs. San Francisco was granted \$96,000. The Governor's budget for 1988-89 proposes renewal of this amount, and an increase of \$1,191,000, earmarked for the development of an AIDS Unit at Napa State Hospital.



Political issues

27. There is ongoing pressure from forces influential in State and Federal politics to test people with mental health problems for antibodies and segregate or otherwise further disenfranchise those who test positive. The impact of such a move on the demand for mental health services has not been assessed.
28. Long-term mental health institutions are settings where it is possible that "screening" for HIV antibody may become routine. The imposition of antibody testing on this population could lead to separation of patients who are tested from the general patient population.

E. POLICY REAFFIRMATION

1. DPH will ensure that mental health services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, race/ethnicity, culture, sexual orientation, and language should be evident in all service settings.
2. Private providers should be encouraged to participate as fully as possible in the provision of mental health services related to HIV infection.
3. DPH should maintain mental health support services to maximize the patients' potential to maintain themselves at home or in residential facilities. This includes direct care to persons with AIDS and ARC as well as to significant others whose participation in providing care at home is essential to its success.
4. Expansion of mental health services related to AIDS should parallel the development of satellite programs for primary care and specialized outpatient clinics. In other words, a satellite program designed to provide primary care to more discrete population groups (e.g. women with AIDS/ARC) or to particular neighborhoods with a high prevalence of HIV infection should be complemented with an expansion of mental health services to the same population and its support systems. Of particular concern is the availability of psychiatric assessments in instances where dementia and other forms of neurological disorder are associated with HIV infection.



XIII. SUBSTANCE ABUSE SERVICES

## A. GOALS

The relationship between AIDS and substance use is exceptionally intimate and complex. Substance users are at particularly high risk for exposure to and subsequent transmission of HIV as a consequence of (a) sharing contaminated needles or (b) engaging in unsafe sexual activity when disinhibited by substance use. Once infected, the progress to clinical disease is accelerated by a health status already compromised by substance use. Their treatment is often complicated, and the availability of personal and community support services also limited, by their substance abuse.

As far as AIDS prevention is concerned, the goals of DPH's program may be best described as incremental and pragmatic. The initial goal is to end the sharing of contaminated needles and the unsafe sexual activity associated with substance use. The larger goal is to end the substance use which encourages needle sharing and unsafe sexual activity. In providing health care to persons with AIDS/ARC and a concurrent substance abuse problem, the underlying goal is to end substance use which undermines attempts to slow the progress of the disease. Since the prognosis for anyone with AIDS is quite grim, in many cases the joint goal of AIDS care and substance abuse services shifts at some point to controlling the substance abuse sufficiently to ensure that the balance of the individual's life is lived with as much dignity and comfort as possible without compromising the well-being of others.

## B. ELEMENTS OF SERVICE

AIDS education services in general can be categorized in a variety of ways which do not result in mutually exclusive groups. The same is true for substance abuse services. Substance abuse services are frequently described in the following ways:

- (a) Services defined by clients' substance(s) of choice: stimulants, opiates, alcohol, poly-drug, etc.
- (b) Services defined by the place in which they occur: in jails, in schools, in treatment centers, in hospitals and clinics, in the workplace, in shelters and foodlines, on the street and in other natural settings of at-risk populations, etc.
- (c) Services defined by the community targeted: groups defined by their race or ethnicity, gender, sexuality or sexual orientation, age, neighborhood, activity (e.g. prostitutes), etc.
- (d) Services defined by focus of activity: prevention through education, prevention through intervention, detox, care and treatment, research, staff training, etc.



- (e) Services defined by modality: community education, residential, non-residential, etc.

For purposes of this report, the description of AIDS-related substance abuse services will be organized by modality, which is consistent with most of the data available about service capacities and budgets. It is important to recognize, however, that some of the services described may regard a different taxonomy as being more indicative of their emphasis and primary concerns.

1. Community education encompasses outreach efforts targeted to large audiences as well as individuals. It also entails some elements of one-on-one counseling and work with drop-in groups. In general, the structure for clients is minimal and open-ended. Community education includes presentations and the distribution of literature at community forums and "town meetings", at street fairs and plays, in schools, jails, shelters, foodlines, and other natural settings of at-risk populations. HIV testing with pre- and post-test counseling and training in cleaning needles would also fall into this category of substance abuse services.
2. Non-residential services include outpatient detox, outpatient maintenance, various categories of outpatient counseling (individual, family, group), and other rehabilitation activities.
3. Residential services include residence- or hospital-based detoxification units as well as relatively long-term residential treatment programs which are either drug-free or which offer some flexibility in demands for abstinence from AIDS-affected substance abusers.
4. Research activity is often associated with the evaluation of specific interventions and services. In addition, there is research in needle use ethnography, sexual practices ethnography, and HIV seroprevalence and other areas of needs assessment. While not a formal "modality" within CSAS, research related to CSAS programs and concerns will be touched on in this section. A more complete discussion can be found in the chapter on Surveillance, Epidemiology, and Related Research.
5. The training of substance abuse service program staff in dealing with AIDS-affected clients and of health care and other support service staff in accommodating patients/clients with a dual diagnosis of HIV infection and substance abuse is addressed in the chapter on Provider Education. Some highlights that are substance-abuse specific will be noted here.

## C. CURRENT SERVICES

It has been argued above that all 16,000 clients of Community Substance Abuse Services, as well as the participants in voluntary community support

services such as Alcoholics Anonymous, are involved to some degree in AIDS prevention programs, regardless of the specific mode and focus of the particular program in which they are involved. Stopping the spread of AIDS cannot be contemplated without an appreciation of this argument. All programs whose objectives include prevention or treatment of substance abuse are AIDS prevention programs. Some, however, are more active than others in promoting awareness of the connection between substance abuse and the transmission of HIV, and between substance abuse and the development of clinical AIDS.

The wisdom of this argument notwithstanding, what follows is a discussion of programs which have received funding labeled "AIDS-specific". It must be recognized that, as far as AIDS prevention and support services are concerned, the latter constitute only a fraction of the overall effort and potential of San Francisco's continuum of substance abuse services.

### Community Education

The Multicultural Prevention Resource Center, Asian-American Residential Services, and Horizons Unlimited (Projecto Ayuda) cooperate in providing AIDS prevention education to a variety of programs serving racial and ethnic minority groups.

Youth Environment Studies, Inc. (YES), formerly operating under the aegis of the Mid-City Consortium to Combat AIDS (MCtCA), receives State funding directly from the Department of Health Services and through San Francisco Community Substance Abuse Services, and Federal funding from the National Institute of Drug Abuse (NIDA) through the San Francisco DPH AIDS Office. This supports 10 community health outreach workers (CHOWs) who provide education and health promotion to IV drug users out of treatment in the Tenderloin, Polk Street, South of Market, Haight, Western Addition, and Mission districts. A specific component of this program focuses on adolescent runaways and another focuses on prostitutes. Their outreach includes street intercepts and counseling, distributing comic strips and other literature which illustrate the most effective methods for decontaminating hypodermic syringes, and distributing one-ounce bottles of household bleach. Project staff also provide referrals to appropriate social and health services and monitor needle-sharing behavior and sexual practices.

YES's program includes the exclusive focus by four additional CHOWs on female sexual partners of IV drug users (IVDUs) who are not themselves IVDUs. Two of these CHOWs will work in the southeastern section of the city and two in the Mission, Tenderloin, and Western Addition.

Bayview-Hunter's Point Foundation (BVHP) also receives NIDA funding through San Francisco DPH's AIDS Office to support four CHOWs providing similar services to IVDUs in Visitation Valley, Oceanview, Bayview-Hunter's Point, Potrero Hill, Merced Heights, and Ingleside (OMI). CHOW training and interface with CHOWs based at YES will be coordinated by project staff based at DPH's AIDS Office.



The same NIDA grant to DPH's AIDS Office supports a half-time health worker at the Department's Forensics AIDS Project to work specifically with IVDUs in San Francisco jails. This health worker joins a staff of five at the Forensics AIDS Project who provide AIDS prevention education in detention facilities and training for facility staff. The project is described more fully in the sections on public and provider education.

### Non-residential

18th Street Services is an outpatient substance abuse counseling center for gay men in San Francisco which provides: (a) comprehensive education to all clients about their risk for AIDS and what they can do about it; (b) street-based education and outreach on AIDS and substance abuse to out-of-treatment adults and adolescents in the Tenderloin and Polk Gulch neighborhoods; and (c) substance abuse treatment for men with AIDS or ARC or who are HIV antibody positive. The goal of the program is twofold: (a) to reduce or stop at-risk behaviors for adolescents or adults who are unable to commit to treatment; and (b) to provide comprehensive services to all clients with the emphasis being clean and sober living. All clients are encouraged to utilize 12-Step programs. The agency is currently treating over 140 active clients of whom approximately 80% are HIV positive.

PMHS' Operation Concern/Operation Recovery provides individual and group counseling to gay IV stimulant users who are diagnosed with AIDS/ARC or who test antibody positive. Their partners and significant others are also encouraged to participate in counseling as co-dependents, to assist in providing a support system for clients' recovery from IV stimulant substance abuse and adoption of safe sexual practices. Often it is only possible to reach a person who is using drugs through his or her co-dependents. Similarly, working with co-dependents and significant others is essential to ensure that treatment efforts have the best possible chance of success.

Methadone maintenance and related counseling are provided by three programs to approximately 38 persons who have AIDS/ARC or who are seropositive at any given time: UCSF's Substance Abuse Services at San Francisco General Hospital's Ward 93, Bayview-Hunter's Point Foundation, and Westside Community Mental Health Center. Clients receive a daily dose of methadone and are seen weekly or more often by a counselor.

UCSF Substance Abuse Services, a hospital-based program, deals with cases that are medically more complicated and is the designated county methadone provider for opiate addicts with AIDS/ARC. On Ward 93, as of January 1988, 40 of the 175 individuals receiving treatment had AIDS or ARC or were HIV antibody positive with significant medical or psychiatric symptoms. Of those 40 patients, 18% had AIDS, 47% had ARC, and 35% were HIV positive.

CSAS contracts with Westside Community Mental Health Center for non-methadone detoxification services for persons who test HIV positive or who have been diagnosed with AIDS or ARC. CSAS also contracts with Bay Area



Addiction, Research, and Treatment (BAART) which, through a program called FACET, provides individual and group counseling for pregnant and newly delivered mothers who are opiate or polydrug addicted who are at high risk of HIV infection. Services include parenting classes and practical support to assist these mothers in caring for themselves and their children.

UCSF's AIDS Health Project (AHP) has staff based at Ward 92 who provide assessment and consultation services to AIDS/ARC patients at Unit 5A and Ward 86 who indicate substance abuse problems. This program estimates that approximately 35% of all AIDS patients seen at SFGH have substance abuse concerns. The services provided include: crisis intervention, psychiatric consultation, drug treatment referral, and consultation with providers in various clinics at the hospital. High risk patients are seen not only on Ward 86 and Unit 5A but in such other clinics as neonatal and pediatrics.

### Residential

Community Substance Abuse Services has contracted with Baker Places, Inc., for a 21-bed residential treatment program specifically for substance abusers with AIDS/ARC. Unfortunately, the agency has not been able to locate a suitable facility in the 12 months that have passed since the contract was let. The proposed program will provide the following under one roof: (a) basic 24-hour staffing appropriate to a substance abuse treatment program; (b) treatment for a range of substance abuse (including amphetamines, opiates, and alcohol); (c) rules which call for abstinence but which identify sanctions other than a long exile from the program if these rules are broken; (d) on-site detoxification to ensure program continuity and a "short loop" back into the program if needed; (e) access to AIDS-specific outpatient care when needed; (f) rooms and bathroom facilities which make home health care for those who are very sick feasible; and (g) AIDS-specific home care on an as-needed basis. Residents entering the terminal stage of AIDS will in most cases be transferred to a subacute care facility.

In the chapter on Chronic Care, Housing, and Related Support Services, there is a discussion of other housing services which are prepared to work with persons with a dual diagnosis of AIDS and substance abuse. Since they are not substance abuse treatment services per se, they are not described more fully here.

### Research

The University of California at San Francisco's Center for AIDS Prevention Services (CAPS), formerly known as the Substance Abuse and Mental Health in AIDS (SAMHA) Center, is supported by a grant from the National Institute of Mental Health (NIMH) and the National Institute of Drug Abuse (NIDA). It creates a working environment in which academic researchers at UCSF and UCB, county health officials at DPH, and minority health professionals at Bayview-Hunter's Point Foundation can benefit from a pooling

of knowledge, skills, and community activities. The focus of the center is on developing and testing preventive interventions and on formulating and disseminating health policy guidelines. Investigations specific to AIDS and substance abuse include studies of (a) the impact of residential treatment on AIDS prevention, (b) the impact of methadone maintenance on sexual behavior and needle use, and (c) the impact of HIV antibody testing and notification on IV drug users. The funding for CAPS is reported with funding associated with Surveillance, Epidemiology, and Related Research, not as funding specific to substance abuse services.

The program of outreach to IVDUs out of treatment, their female sexual partners, and prostitutes, in which DPH's AIDS Office is working cooperatively with Youth Environment Studies and Bayview-Hunter's Point Foundation, mirrors programs in five other urban centers across the country. DPH's agreement with NIDA provides for extensive data collection about and evaluation of the process implemented in San Francisco and collaboration with a nationally managed assessment of outcomes.

### Training

The AIDS and Substance Abuse Education Program (ASAP) of the UCSF AIDS Health Project provides consultation and training about the intimate and complex interaction between AIDS and substance abuse. ASAP assists substance abuse agencies in dealing with AIDS and assists AIDS agencies in dealing with substance abuse. Services include formal training on such topics as substance abuse assessment, counseling strategies for substance abuse clients with AIDS concerns, and basic AIDS information. Consultation services center upon treatment planning for individual clients and programmatic or agency needs concerning substance abuse and AIDS training. These services also address particular biases about substance users that providers may have. All drug and alcoholism treatment programs in San Francisco have been contacted and have had in-service training or consultation for staff members. ASAP attempts to target the specific needs of various subgroups of substance abusers (e.g. gay men, ethnic minorities) in all of its training and consultations. Some direct education of clients in substance abuse treatment settings is also provided. An estimated 1,200 service providers in San Francisco will receive training or consultation from this program in FY 1987-88.

The NIDA-funded project for outreach to IVDUs, their female sexual partners, etc., includes a training component for community health outreach workers. The California Department of Health Services has indicated an interest in making such training available state-wide. If this materializes into a contract between California DHS and Youth Environment Studies, the training responsibilities currently associated with NIDA funding in San Francisco may be subsumed by the state-wide training program.



D. FACTORS INFLUENCING THE DEVELOPMENT OF AIDS-RELATED SUBSTANCE ABUSE SERVICES

General observations on access to services

1. Given the circumstances under which HIV is communicable, all elements of substance abuse prevention, detoxification, and treatment services are ipso facto AIDS prevention services. By extension, all shortages/shortcomings of existing substance abuse services are shortages/shortcomings in AIDS prevention services. The only circumstance under which AIDS prevention education among substance abusers is not also substance abuse intervention is when the education is limited to particular patterns of substance use (e.g. needle sharing or getting high before sex) and not the substance use itself.
2. Eighty-nine percent of AIDS cases reported in San Francisco with a history of IV drug use are gay/bisexual men; 86.3% of these are white, 8.3% Black, 4.6% Latino, 0.6% Asian/Pacific Islander, and 0.2% Native American. Of the 62 women (15) and heterosexual men (47) with AIDS and a history of IV drug use, more than half (32) are Black and one fifth (10) are Latino. Figures are not available for those who use non-intravenous substances that put them at risk of HIV infection.

Understanding the demand for services at all levels and the demographics of AIDS cases in San Francisco, substance abuse services that target gay and bisexual men are absorbing an enormous percentage of the demand. Similarly, the agencies that serve racial and ethnic minorities and/or have multiple language capabilities are stretched.

3. People with symptomatic HIV infection or AIDS/ARC may need services that are wheelchair accessible. Most substance abuse services are not designed for substance using adolescents although this is a population truly at risk for HIV infection. Residential programs rarely allow a woman with dependent children to enter a program without first placing the child in some form of foster care. These and other issues of access will become increasingly important.

Treatment issues

4. Substance abuse compromises further an already-compromised immune system, tends to accelerate the progress of clinical disease, and often precludes certain treatment protocols. The resulting drain on acute care resources is intensified.
5. People who abuse substances often do not have a primary care provider and/or cannot make their general health a priority. They



therefore tend to seek care later in their illness, are sicker, and require more complicated and lengthy medical treatment than other patients with HIV infection-related illnesses.

6. Substance use and its implications for HIV infection impact not only the active user but all those who are closely involved with that person (family, lovers, children, friends). These significant others need to deal with the substance user's risk and, if a lover, with his or her own potential risk. Treatment of the substance user must be expanded to include co-dependents and other members of family units (both gay and heterosexual) who are affected by and affect the user's ability to accept or seek care.

#### Service delivery issues

7. Seroconversion rates among women and men (gay/bisexual men, men who have sex with other men but do not consider themselves to be gay/bisexual, and heterosexual men) who abuse substances (particularly those who share needles) are higher than among gay/bisexual men who are not substance abusers. Seroconversion rates among IV drug users are higher for nonwhite than for white heterosexuals. Consequently the incidence of AIDS/ARC among all substance abusers is expected to rise at a faster rate in the long run than among gay/bisexual men who are not substance abusers. This will be reflected directly or indirectly in increases in the proportion of cases who are women and indirectly in the proportion who are children.
8. There are various drug subcultures and it is not only intravenous drug users who are at risk for HIV infection. Those who use alcohol, cocaine, amphetamines, etc., are disinhibited when "using" and likely to engage in high risk sexual behaviors. Services need to be sensitive to the variety of drug using communities and target their treatment and prevention programs appropriately.
9. Many of the assumptions about the wants and needs of PWAs/ARC which underlie most of the services on the current health care/support services continuum are not valid if substance abuse is a factor. For example, a home health care/in-home hospice program which assumes that each client/patient has a personal support system that can be galvanized and constructively integrated into the home health care plan does not work well in situations where the personal support system is nonexistent or not particularly responsible. As a result of the effects of the substance they use, substance abusers may be non-compliant, anti-social, or self-destructive. Current services are typically not designed to accommodate individuals who have specific psychosocial needs related to their substance abuse.

10. Established substance abuse treatment programs typically focus on the future benefits of a clean and substance-free lifestyle. Even methadone maintenance programs, which begin by substituting one substance use for another, are promoted as stepping stones to a drug-free lifestyle. For someone with AIDS/ARC, prospects of a future are often very limited. The paradox is not lost on patients.
11. Treatment programs, both residential and non-residential, often require clients to be clean and sober before they will be accepted. Many substance users with HIV infection need prescribed medication that can be mood altering. This creates a dilemma both for the patient (am I really clean and sober?) and for the program.
12. Patients of methadone programs who are infected with HIV may be too ill to come in for methadone maintenance services since they are home-, hospital-, or hospice-bound.
13. The number of babies born to cocaine addicted mothers is increasing. Obviously at risk for HIV infection, these children have special needs. Few services will allow mothers to stay with their children, and foster care placement is emotionally and practically a sensitive issue.
14. Drug using is often a pattern of living. The prevention of HIV infection is not limited to treatment and education but also includes the provision of day care, for both adults and adolescents. Day care provides vocational opportunities for some individuals and a place for respite and support for those wishing to avoid risk taking behavior.
15. The results of UCSF's Center for AIDS Prevention Services (CAPS) research may have implications for planning future AIDS prevention/substance abuse services.
16. In January 1988, John R. Hayes completed a survey of needs and programs related to AIDS and IV drug use prevention in San Francisco. The survey was commissioned by the SFDPH AIDS Office. His report will undoubtedly help to shape plans for services to IV drug users the next few years.

#### Funding issues

17. State Department of Health Services (DHS) funding used to initiate many of the AIDS-specific substance abuse programs in San Francisco was not renewed after FY 1986-87. Increased Federal appropriations for substance abuse services have been made available to local jurisdictions through the State Department of Alcohol and Drug Programs (DADP). However, the formula used by DADP to determine



how much each local jurisdiction would receive did not weigh heavily the incidence or prevalence of AIDS/HIV infection in the jurisdiction. The net result has been that the increase in San Francisco's allocation of Federal prevention and substance abuse treatment dollars has been sufficient only to maintain in FY 1987-88 the AIDS-specific programs from which State DHS funding was discontinued at the end of FY 1986-87.

18. There has not been as smooth a working relationship as would be desirable within the California Health and Welfare Agency, which serves as the umbrella for DHS and DADP, regarding the appropriate role for each department in dealing with the AIDS epidemic. The impact on local jurisdictions has taken the form of mixed messages and policy flipflops regarding the use of DHS information/education funding for AIDS prevention among substance abusers.
19. The National Institute of Drug Abuse (NIDA), the State Department of Health Services (DHS), and San Francisco's Community Substance Abuse Services (CSAS) are all contributing to the support of street outreach intervention methods for contacting out-of-treatment intravenous drug users, their sexual partners, and prostitutes for counseling, referral, and monitoring of behavior. It is anticipated that this model will continue to be relatively well supported through categorical funding for some time. While such outreach is essential, a comparable expansion of treatment services is necessary to accommodate those encouraged to seek care.
20. Constraints within the City and County of San Francisco will impact the ability of Community Substance Abuse Services to expand clinical services beyond the current overutilized capacity. Methadone maintenance, detoxification, and research programs are to be collapsed with administration into one unit of SFGH.

#### Political issues

21. There is ongoing pressure from forces influential in State and Federal politics to mandate antibody testing and to segregate or otherwise disenfranchise those who test positive. The impact of such testing has not been assessed but it is likely that it would provide, at the minimum, a disincentive for substance users to seek treatment.

#### E. POLICY REAFFIRMATION

1. DPH recognizes that all current substance abuse services are in some measure AIDS prevention programs, and that all AIDS education programs in this context are substance abuse prevention programs as well. The "AIDS agenda" (substance abuse treatment as prevention,



education and outreach, counseling for partners and families, etc.) will be a specific item in all program descriptions developed for FY 1988-89.

2. DPH recognizes that preventing the transmission of AIDS may require extraordinary measures, such as educating IV drug users about how to sterilize their syringes, which may create paradoxes for programs whose goals include stopping substance abuse.
3. DPH recognizes that substance abusers with AIDS/ARC present special problems for providers of health care and other support services. Support services specific to the needs of substance abusers should be developed and maintained.
4. DPH will ensure that substance abuse services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture, and language should be evident in all service settings. Training for both AIDS and substance abuse providers will be emphasized, focusing on the special needs of substance users for AIDS providers and AIDS-specific issues for substance abuse professionals.
5. DPH will establish a priority in the development and continuation of substance abuse programs that allow families to stay together whenever possible.
6. DPH recognizes that there are currently waiting lists for methadone maintenance slots, drug-free outpatient programs, and residential treatment. It will establish a priority for these treatment programs and therefore prevention of HIV transmission to be expanded.
7. DPH recognizes that AIDS service programs are often not organized or staffed in a way that easily accommodates people with substance abuse histories. It will assure, however, that this is not used as an excuse for turning clients away if it is at all possible to care for them, and it will assure that all clients receive appropriate referrals.



#### XIV. ADMINISTRATIVE SUPPORT AND COORDINATION

##### A. GOALS

The goal of the administrative services supporting AIDS programs in San Francisco is to ensure that the community's response to the epidemic is equal to the task and cost-effectively managed. These services are also concerned that the financial burdens of meeting the demands of the epidemic are distributed reasonably between the public and private sectors and, within the public sectors, distributed fairly among local, state, and national resources.

##### B. ORGANIZATIONAL STRUCTURE AND DIVISION OF RESPONSIBILITIES

Except where noted, all of the publicly funded services described in this document are provided directly by the Department of Public Health or by community-based contractors of the Department.

The Department is governed by a seven-member Health Commission appointed by the Mayor for staggered four-year terms. The Director of Health is the chief administrative officer of the Department appointed by the Commission.

Under the Director of Health, there are four major subdivisions of the Department, each of which provides AIDS-related services. Community Public Health Programs include (a) Health Centers involved in anonymous antibody testing, and primary care for persons with ARC; (b) the Bureau of Family Health, which provides liaison to the San Francisco Unified School District's AIDS education efforts and manages pregnancy testing, prenatal, and perinatal clinics at the Health Centers; (c) the Bureau of Communicable Disease Control, which manages the City's sexually transmitted disease clinic and tuberculosis clinic, in addition to serving as liaison to community blood banks and providing some contact tracing/recipient education; (d) the Public Health Laboratory, which provides laboratory services, specifically HIV antibody testing; and (e) Public Health Nursing, which provides in-house nursing assessments of patients with AIDS and ARC.

Community Mental Health Programs is the umbrella for Community Mental Health Services, Community Substance Abuse Services, and Forensic Services.

San Francisco General Hospital is the County's general acute care facility. SFGH's specialized AIDS services include a dedicated inpatient unit (5A) and comprehensive outpatient services at Ward 86. People with AIDS/ARC are also seen by SFGH-based dental services and a variety of satellite clinics. Laguna Honda Hospital is the County's long-term care facility. The vast majority of patients are elderly. Laguna Honda Hospital's provision of services to AIDS patients has been limited to date.

The Director established the AIDS Office in 1983, a special arm of his own office, to assist primarily with contract development and administration and to help with planning. The Office was reorganized in 1986 and several



formerly disparate AIDS functions were consolidated under it. The Office is now also responsible for AIDS surveillance and DPH's participation in epidemiologic studies, as well as the administration of specific grants involving inter-divisional cooperation and a variety of contracts for education programs, chronic care, and related support services.

The Office of Planning and Program Support provides the Director with general assistance in planning and liaison to the California Legislature and San Francisco's Congressional delegation in Washington, D.C.

### C. ADVISORY GROUPS

There are a number of groups which contribute in one way or another to the Department's policies and planning for AIDS services. The concerns of some are general, some specific to a particular subdivision of the Department, and others have developed in response to community-based concerns. Some are more active than others; some have been active in the past and have become inactive. The most active include the following:

1. The Mayor's AIDS Task Force:

Dr. Werdegarr and other senior staff of DPH, Dr. Sande and UCSF's AIDS specialists at SFGH, Commissioners Lee and Foster and others. Their main function has been to keep the Mayor apprised of emerging epidemiological trends, diagnosis and treatment issues, and prevention strategies.

2. The Director's AIDS Medical Advisory Group:

Physicians from DPH, SFGH, UCSF, the San Francisco Medical Society, Bay Area Physicians for Human Rights, and others from private practice. Their main function has been to help keep the Director's communication lines to the medical community open.

3. The Departmental AIDS Committee:

Representatives of all the major subdivisions of DPH providing AIDS-related services. Their main function is to advise the Director on the development of departmental AIDS policy and program, coordination of programs between subdivisions of the department, and discussion of program strategy.

4. The Director's AIDS Advisory Committee:

Representatives of AIDS contract services agencies, subdivisions of DPH providing AIDS services, private-sector providers, and community interest groups (e.g. people with AIDS/ARC, racial/ethnic minority groups, gay-identified organizations). The group replaces the original AIDS Coordinating Committee and advises the Director

of Health on the development and coordination of AIDS programs for which the Department is responsible. Its scope of interest includes education as well as health care services.

5. The Advisory Committee on AIDS Services in Ethnic Minority Communities:

The Director of Health convened this group to provide a direct avenue of input from San Francisco's ethnic minority communities regarding their concerns about AIDS. There is substantial overlap between this group's membership and that of the AIDS Advisory Committee, and the groups often meet jointly.

6. The Bay Area Health Officers Task Force on AIDS:

The Director of Health in San Francisco has invited area health officers to participate in regular but informal conversations about emerging needs and responses.

There are also several population-specific task forces organized by DPH. These include the AIDS Substance Abuse Task Force, the AIDS Forensics Task Force, and the Perinatal and Pediatric AIDS Advisory Committee.

The San Francisco Unified School District AIDS Task Force focuses on the development of AIDS education guidelines and curricula for school-age youth and teacher training. The AIDS Research Council is composed of representatives of both DPH and UCSF. Its function is information sharing, coordination, and identification of funding for AIDS research.

Community-based organizations or individuals have convened coalitions, committees, and task forces whose principal concerns are the impact of AIDS on their respective constituencies. They include The Latino Coalition for AIDS/SIDA Education and Action, The Black Coalition on AIDS, The Third World AIDS Advisory Task Force, The Women's AIDS Network, The Tenderloin AIDS Network, The Homeless Service Providers Coalition AIDS Subcommittee, The California Prostitutes' Education Project, People with AIDS/San Francisco, The AIDS/ARC Vigil, Mobilization Against AIDS, and the California Hemophilia Association.

The Kaiser Community Council on AIDS Health Care, initiated by the administration of Kaiser Permanente Medical Center in 1985, includes representatives from Kaiser and designated community agencies. Its function is to facilitate the provision of health care for Kaiser Health Plan members who are persons with AIDS/ARC, through cooperation and coordination with community AIDS service providers.

There are, additionally, professional associations with an interest in AIDS with which DPH personnel have contact: the West Bay Hospital Conference, the San Francisco Medical Society, Bay Area Physicians for Human Rights, and Bay Area Lawyers for Individual Freedom.



**D. FACTORS WHICH HAVE A SPECIAL IMPACT ON ADMINISTRATIVE SUPPORT SERVICES, BUDGETING, ETC.**

1. The rapid and ongoing expansion of demand for services discussed above provides enormous pressure.
2. Because AIDS has such a direct and visible impact on so many features of public health and health care, AIDS is sometimes "blamed" for shortcomings in services which existed before AIDS began to take its toll.
3. With one exception in the case of State funding, State and Federal support for AIDS-related services in San Francisco has been in the form of contracts/cooperative agreements issued after a competitive application process. It is clear that DPH has been at a disadvantage in many instances in which local funding has been used to initiate services prior to the availability of State/Federal funding for them. Since the RFPs often preclude using State or Federal grants to underwrite activities for which local funding has already been allocated, and since DPH has initiated such a comprehensive range of activities with local funding, our applications are often limited to proposals to round out an already functioning operation. We will continue to operate with this handicap except when (a) block grants are provided, (b) local matching funds are required, or (c) we delay initiating particular types of services until State or Federal funding is available.
4. State and Federal grant and cooperative agreement funding is frequently provided on fiscal cycles that do not coincide with DPH's fiscal year.
5. Contracts with the State Department of Health Services are a particularly heavy administrative burden for DPH: contract terms are very narrowly defined and inflexible; contract processing typically requires more than five months (up to nine in some instances) after the initial proposal has been approved; DHS staff are frequently obliged to renege on verbal commitments made in contract negotiations; prospects of contract renewal are usually quite unclear. Cooperative agreements with the Centers for Disease Control and the Health Resources and Services Administration are, in contrast, reasonably flexible and quickly processed.
6. The State Department of Health Services is inclined in many instances to bypass local departments of health when contracting for local services. In the past six months there have been six instances in which DHS elected to contract directly with (a) community-based organizations for AIDS prevention education, (b) community-based organizations for a study of health care needs



- specific to members of racial and ethnic minority groups, and (c) skilled nursing facilities. In three of the six cases, DPH was not even permitted to apply for the funds offered.
7. DPH's own contracting procedures have become much more complex in light of (a) Health Commission review of all contracts and (b) the provisions of city ordinances which address contract organization ownership and foreign investments. Civil Service review of all intentions to contract has been part of the process from the beginning, but it nonetheless contributes to the administrative complexity of contract management.
  8. Filling grant-funded positions is an enormously complex and time-consuming administrative process. Where State-funding is involved (with 5-9 month delays in processing contract documents), the problems are magnified.
  9. There are two areas of bureaucratic turf in the City/County of San Francisco that are particularly difficult to negotiate in the midst of a rapidly expanding epidemic: (a) the requirements for bringing new personnel on board and (b) the restrictions on the acquisition and deployment of computer hardware and software.
  10. Beginning in FY 1986-87, there has been a general understanding at DPH that new and expanded AIDS services should depend as little as possible on ad valorem funding. This is not an anti-AIDS position. It simply reflects the reality that other needed services have been neglected in order to make funding available for AIDS and the pinch is being felt everywhere.
  11. Until recently San Francisco has been able to manage services for PWAs/ARC regardless of the limitations on State/Federal funding and programs and private insurance. San Francisco has reached its limit, thus making us increasingly dependent on these other financing systems. For the first time in San Francisco there is a shortage of those services not otherwise reimbursed, most notably for the chronic care components of the system. The epidemic now requires that other finance systems change their policies to permit the development of these needed services. If there is no change in this regard, the burden on the acute care system will outstrip these resources.
  12. The wide variety of community advocacy groups that have been developed in conjunction with the epidemic appropriately demand that their various concerns be appreciated and addressed in plans for AIDS services. An adequate "hearing" for these interests and the development and implementation of programs often require more lead time and staff support than is currently available to the Department.

## E. POLICY REAFFIRMATION

1. The Department of Public Health reaffirms its commitment to ensuring that San Francisco's response to the AIDS epidemic is equal to the task in prevention and care and is cost-effectively managed.
2. DPH also reaffirms that the financial burdens of meeting the demands of the epidemic should be distributed reasonably between the public and private sectors and, within the public sector, distributed fairly among local, state, and national resources.
3. DPH recognizes that the interests of community advocacy groups and community-based organizations must be appreciated and addressed in plans for AIDS services.
4. DPH maintains that, in situations where the local department of health has an established and credible track record in AIDS prevention and health care services, State and Federal agencies should be encouraged to support these services through block grants to the local department. Competitive application procedures in these situations create an administrative burden on all parties that does not serve the epidemic well.
5. In situations where there are opportunities for direct funding of community-based organizations, the funding agency involved should encourage close cooperation with related programs in the continuum.
6. DPH expects the California Department of Health Services to streamline its contract procedures to (a) provide much faster processing of contracts and (b) give contractors more flexibility to respond quickly and constructively to emerging needs in the area of service for which the funds are earmarked. DPH recognizes that the greater utilization of block grants mentioned above would accomplish this goal as well.
7. DPH requests that State and Federal funding be offered to local jurisdictions in a manner which encourages joint utilization of State/Federal and local dollars. State and Federal funding restrictions which arbitrarily penalize local jurisdictions which have taken the initiative to respond to needs created by the epidemic, simply because they have taken the initiative, should be withdrawn.
8. DPH encourages the City and County of San Francisco to recognize that an epidemic is in progress and that it is necessary to expedite personnel classification, testing, and requisition processing requirements that contribute to delays of more than two months in filling critical positions. CCSF should also expedite

requirements that all computer equipment (even equipment which is leased or purchased with grant funds) be part of a plan developed long before needs raised by the epidemic could possibly have been anticipated.

9. The performance of DPH-affiliated AIDS services should be assessed on a regular basis.





XV. 1987-88 BUDGET SUMMARIES AND COST ESTIMATES

FUNDING DISTRIBUTION FOR ALL AIDS SERVICES IN SAN FRANCISCO  
CONFIRMED AT 2/29/88 FOR FISCAL YEAR 1987-1988

SERVICE CATEGORY	CITY BUDGET	[Grants to CCSF from] STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED
SURVEILLANCE, EPIDEMIOLOGY AND RELATED RESEARCH	125,933	118,544	2,531,712	2,098,643	4,874,832
PUBLIC EDUCATION	1,036,308	1,402,323	1,861,010	506,762	4,806,403
PROVIDER EDUCATION AND AND STAFF SUPPORT	181,955	111,333	345,136	306,752	945,176
PRIMARY AND SPECIALIZED OUTPATIENT CARE	5,364,365	0	2,793,943	13,479,369	21,637,677
HOSPITAL INPATIENT CARE	11,075,925	0	0	31,380,193	42,456,118
CHRONIC CARE, HOUSING AND RELATED SUPPORT SERVICES	3,296,873	537,042	572,902	4,271,151	8,677,968
AIDS-RELATED MENTAL HEALTH SERVICES	2,519,946	156,097	38,499	433,089	3,147,631
AIDS-SPECIFIC SUBSTANCE ABUSE SERVICES	27,131	735,531	1,031,249	100,000	1,893,911
ADMINISTRATIVE SUPPORT AND COORDINATION	824,809	0	0	0	824,809
TOTALS	\$24,453,245	\$3,060,870	\$9,174,451	\$52,575,959	\$89,264,525

NOTES: 1. "KNOWN OTHER" in this instance includes:

2,874,687	Federal and State Grants given directs to other providers
2,213,559	Private donations and private foundation grants
47,487,713	Payments from Medicare, MediCal, private insurance companies, and recipients of services. HMO services are factored in here as well.

\$52,575,959 TOTAL OTHER

2. "CITY BUDGET" figures for Primary Care and Hospital Inpatient Care include revenues from Medicare, MediCal, private insurance and patient fees as well as tax dollars.



FUNDING DISTRIBUTION FOR AIDS SURVEILLANCE, EPIDEMIOLOGY AND RELATED RESEARCH  
IN SAN FRANCISCO, CONFIRMED AT 02/29/88 FOR FISCAL YEAR 1987-1988

PROGRAM/Provider	CITY BUDGET	[Grants to CCSF from] STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED
<b>SURVEILLANCE</b>					
DPH/AIDS Office	83,955	84,346	136,165		304,466
DPH/Disease Control	41,978				41,978
Irwin Memorial Blood Bank			208,557		208,557
<b>EPIDEMIOLOGY</b>					
DPH/AIDS Office		34,198	1,362,032		1,396,230
UC Berkeley				(Not avail)	0
UCSF/Dentistry				(Not avail)	0
UCSF/SFGH				(Not avail)	0
Western Consortium for Public Health				(Not avail)	0
<b>BEHAVIOR RESEARCH</b>					
Community surveys-					306,325
Asian/Pacific Islander (TBD)			100,000		
Black (TBD)			80,000		
Latino (TBD)			80,000		
Heterosexuals w/multiple or high risk partners (SFAF)			46,325		
CAPS-					2,098,643
UCSF				1,649,886	
Bayview-HP Foundation				448,757	
Youth Environment Studies			271,852		271,852
DPH/AIDS Office			99,894		99,894
<b>CCSF CONTROLLER</b>					
Indirects			146,887		146,887
TOTALS	\$125,933	\$118,544	\$2,531,712	\$2,098,643	\$4,874,832

NOTE: "KNOWN OTHER" in this instance is a grant direct to UCSF from NIDA/NIMH for \$2,098,643.

FUNDING DISTRIBUTION FOR PUBLIC EDUCATION IN SAN FRANCISCO  
 CONFIRMED AT 02/29/88 FOR FISCAL YEAR 1987-1988

PROGRAM/Provider	CITY BUDGET	[Grants to CCSF from] STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED	MINORITY Percent	CONCERNS Portion
<b>OUTREACH EDUCATION</b>							
DPH/AIDS Office		182,581	30,717		213,298	50%	106,649
DPH/Disease Control	163,942				163,942	40%	65,577
DPH/Family Health	87,689		166,250		253,939	49%	124,430
DPH/Forensics			131,644		131,644	53%	69,771
DPH/Health Centers	78,500				78,500	50%	39,250
Asian Amer. Rec. Serv.	30,000		99,400	65,000	194,400	100%	194,400
Bayview-HP Foundation	36,006	127,627		1,650	165,283	100%	165,283
CA Prostitute Education Project (CAL-PEP)				45,000	45,000	50%	22,500
Inst. Familiar de la Raza	76,545	85,273			161,818	100%	161,818
KPOO-FM Radio				19,341	19,341	100%	19,341
PPMC/Operation Concern	32,124			658	32,782	15%	4,917
SF AIDS Foundation	366,465	124,943		359,283	850,691	25%	212,673
UCSF AIDS Health Project	155,171			2,267	157,438	15%	23,616
Youth Environment Studies			160,611		160,611	45%	72,275
Other contractors		105,270			105,270	40%	42,108
<b>TESTING AND COUNSELING</b>							
DPH/AIDS Office and HC1		242,624	92,376		335,000	25%	83,750
DPH/City Clinic			87,264		87,264	40%	34,906

PROGRAM/Provider	CITY BUDGET	(Grants to CCSF from) STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED	MINORITY Percent	CONCERNS Portion
DPH/Laboratory					357,782	30%	107,335
ATS		233,080					
PMD		45,262	38,401				
City Clinic			41,039				
Multicultural Prevention Resource Center			234,787		234,787	100%	234,787
SF AIDS Foundation			187,787		187,787	25%	46,947
UCSF/AIDS Health Project							
ATS	9,866	202,839	314,673	13,563	663,403	35%	232,191
City Clinic			122,462				
Others			80,497		80,497	50%	40,249
CCSF CONTROLLER							
Indirects		52,824	73,102		125,926	0%	0
TOTALS	\$1,036,308	\$1,402,323	\$1,861,010	\$506,762	\$4,806,403	44%	\$2,104,771

NOTES: 1. "KNOWN OTHER" in this instance includes:

377,421	Private donations
19,341	Grant direct to provider from the US Conference of Mayors
110,000	Grants direct to providers from California DHS
=====	
506,762	Total

2. AIDS-specific funding for school education has been included under the heading of PROVIDER EDUCATION, since the focus of activities directly supported by this funding is teacher training.

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FUNDING DISTRIBUTION FOR PROVIDER EDUCATION AND STAFF SUPPORT IN SAN FRANCISCO  
 CONFIRMED AT 02/29/88 FOR FISCAL YEAR 1987-1988

PROGRAM/Provider	CITY BUDGET	(Grants to CCSF from) STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED	MINORITY Percent	CONCERNS Portion
HEALTH CARE							
-----							
UCSF/APEP				(not avail)			
UCSF/APEX				(not avail)			
UCSF/SFGH			57,245	(not avail)	57,245	45%	25,760
UCSF/SFGH (conference)				(not avail)			
California Nurses Assoc.		42,255		4,500	46,755	20%	9,351
MENTAL HEALTH							
-----							
Operation Concern	13,767			282	14,049	10%	1,405
UCSF/AIDS Health Project	112,349			5,267	117,616	10%	11,762
SUBSTANCE ABUSE							
-----							
UCSF AIDS Health Project	55,839		115,754		171,593	28%	48,046
EMERGENCY RESPONSE WORKERS AND JAIL STAFF							
-----							
DPH/Forensics AIDS Project		25,901	43,881		69,782	53%	36,984
CLASSROOM TEACHERS							
-----							
SFUSD and DPH/Fam. Health			17,063		17,063	84%	14,333
SFUSD				296,703	296,703	84%	249,231
OTHER							
-----							
DPH/AIDS Office		41,390			41,390	10%	4,139
Polaris Rsrch & Decisions (ethnic minority concerns)			102,465		102,465	100%	102,465
DPH/Planning (conference)				(not avail)			
UCSF/APEP (conference)				(not avail)			

PROGRAM/Provider	CITY BUDGET	[Grants to CCSF from] STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED	MINORITY Percent	CONCERNS Portion
CCSF CONTROLLER							
Indirects		1,787	8,728		10,515		
TOTALS	\$181,955	\$111,333	\$345,136	\$306,752	\$945,176	53%	\$503,476

NOTES: 1. "KNOWN OTHER" in this instance includes:

10,049 Private donations  
296,703 Grant direct to provider from the US Centers for Disease Control  
306,752 Total

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FUNDING DISTRIBUTION FOR AIDS PRIMARY CARE AND SPECIALIZED OUTPATIENT CARE IN SAN FRANCISCO  
 CONFIRMED AT 02/29/88 FOR FISCAL YEAR 1987-1988

PROGRAM/Provider	CITY BUDGET	[Grants to CCSF from] STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED
SF6H OUTPATIENT SERVICES					
Ward 86	3,000,000		58,390		3,058,390
Other SF6H-based clinics	934,800				934,800
SF6H satellite clinics	139,950				139,950
Pharmacy (AZT Program only)			2,735,553		2,735,553
DPH/PUBLIC HEALTH SERVICES					
Hlth Cntr #1 and Central Emergency Aid Station:					
AIDS-specific	250,890				250,890
Est. in-kind	360,000				360,000
Disease Control					
AIDS-specific	103,941				103,941
Est. in-kind	150,000				150,000
Microbiology Laboratory					
AIDS-specific	356,681				356,681
Haight-Ashbury FMC	68,103				68,103
DPH/MENTAL HEALTH DIVISION					
Jail Medical Services	(Not avail)				
OTHER PRIMARY CARE SETTINGS					
				13,479,369	13,479,369
TOTALS	\$5,364,365	\$0	\$2,793,943	\$13,479,369	\$21,637,677

NOTE: SF6H outpatient services have been estimated at \$152.15 per outpatient encounter

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FUNDING DISTRIBUTION FOR HOSPITAL INPATIENT CARE FOR PEOPLE WITH AIDS/ARC IN SAN FRANCISCO  
 CONFIRMED AT 02/29/88 FOR FISCAL YEAR 1987-1988

PROGRAM/Provider	CITY BUDGET	[Grants to CCSF from] STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED
SF General (Estimated in-kind)	11,075,925				11,075,925
Other community hospitals (Estimated in-kind)				31,380,193	31,380,193
TOTALS	\$11,075,925	\$0	\$0	\$31,380,193	\$42,456,118

- NOTES: 1. The estimates for San Francisco General Hospital is based on \$867 per day for 12,775 inpatient days (35 average daily census). This estimate for SFGH's budget is substantially higher than estimates reflected in pervious documents. It reflects an attempt to account more accurately for the burden on the budget rather than an increase in the budget itself. Readers should recognize that the City Budget figure includes revenues from Medicare, MediCal, private insurance and patient fees as well as tax dollars.
2. The estimates for other San Francisco hospitals is based on \$983 per day for 31,923 inpatient days.

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FUNDING DISTRIBUTION FOR AIDS CHRONIC CARE, HOUSING AND RELATED SUPPORT SERVICES IN SAN FRANCISCO  
 CONFIRMED AT 02/29/88 FOR FISCAL YEAR 1987-1988

PROGRAM/Provider	CITY BUDGET	[Grants to CCSF from] STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED
<b>SUBACUTE AND SKILLED NURSING CARE</b>					
-----					
Garden Sullivan Hospital	662,675	58,560	15,040	252,624	988,899
Others			154,842	1,121,030	1,275,872
<b>HOME HEALTH/IN-HOME HOSPICE</b>					
-----					
PPMC/VNA and Hospice of SF					2,947,235
DPH/AIDS Office	918,468	210,900	140,379	1,444,270	
DPH/MIA Office	113,802				
DSS/IHSS	119,416				
<b>HOUSING</b>					
-----					
SFAF Client Services					
Emergency housing	83,444			48,716	132,160
Shanti Project					
Residence Program	423,583			198,061	621,644
Catholic Charities					
Residential hotel support	307,398				307,398
<b>PRACTICAL SUPPORT</b>					
-----					
Shanti Project					
Practical Support Program	189,197	30,048		169,681	388,926
SFAF/Client Services					
Food Bank				249,849	249,849
Open Hand					
Meals delivery				303,530	303,530
<b>ADVOCACY AND CASE MANAGEMENT</b>					
-----					
SFAF/Client Services					
Social service advocacy	267,408			133,390	400,798
DPH/Public Health Nursing					
In-home assessments	102,720				205,466
Case management		102,746			

PROGRAM/Provider	CITY BUDGET	[Grants to CCSF from]		KNOWN OTHER	TOTAL CONFIRMED
-----	-----	STATE	FEDERAL	-----	-----
LEGAL EDUCATION/DISCRIMINATION COMPLAINTS					
-----					
BALIF				100,000	100,000
NGRA				(not avail)	
SF Human Rights Commission	108,762				108,762
NEEDS ASSESSMENTS/COORDINATION					
-----					
DPH/AIDS Office			236,281		236,281
DPH/Planning		118,779			118,779
Westside Community Mental Hlth (Black community)				125,000	125,000
Institute Familiar de la Raza (Latino community)				125,000	125,000
CCSF CONTROLLER					
-----					
Indirect costs		16,009	26,360		42,369
	=====	=====	=====	=====	=====
TOTALS	\$3,296,873	\$537,042	\$572,902	\$4,271,151	\$8,677,968

NOTE: "KNOWN OTHER" in this instance includes:

68,354	Medicare
831,579	Medicaid (MediCal)
754,324	Private insurance/fees
1,393,000	Private contributions
250,000	Grants direct to providers from California DHS
973,894	Other/unspecified reimbursements for SNF care
=====	
\$4,271,151	Total

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FUNDING DISTRIBUTION FOR AIDS-RELATED MENTAL HEALTH SERVICES IN SAN FRANCISCO  
 CONFIRMED AT 02/29/88 FOR FISCAL YEAR 1987-1988

PROGRAM/Provider	CITY BUDGET	[Grants to CCSF from] STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED
-----					
INFORMATION AND ADVOCACY SERVICES					
-----					
Shanti Project					
Information and referral				175,754	175,754
ADULT COMMUNITY SERVICES					
-----					
DPH/CMHS					1,114,369
Day treatment (est. in-kind)	174,160				
Outpatient (est. in-kind)	850,209				
Outpatient (AIDS-specific)	92,000				
UCSF/AIDS Health Project					
Assessments and outpatient	85,214		37,744	6,131	129,089
Shanti Project					
Peer counseling	262,604	60,097		186,842	509,543
Shanti Project					
SFGH counseling	208,159			64,362	272,521
ADULT ACUTE CARE					
-----					
DPH/CMHS					
Adult resident (est. in-kind)	287,763	96,000			383,763
SFGH/Psychiatry					
Emergency Rm. (est. in-kind)	494,606				494,606
(See also SFGH/Acute Inpatient Care)					
GERIATRIC SERVICES					
-----					
DPH/CMHS					65,231
Day treatment (est. in-kind)	6,954				
Outpatient (est. in-kind)	58,277				
CCSF CONTROLLER					
-----					
Indirect costs			755		755
=====					
TOTALS	\$2,519,946	\$156,097	\$38,499	\$433,089	\$3,147,631

NOTE: "KNOWN OTHER" in this instance includes \$433,089 in private contributions

FUNDING DISTRIBUTION FOR AIDS-SPECIFIC SUBSTANCE ABUSE SERVICES IN SAN FRANCISCO  
 CONFIRMED AT 02/29/88 FOR FISCAL YEAR 1987-1988

PROGRAM/Provider	CITY BUDGET	[Grants to CCSF from] STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED	MINORITY Percent	CONCERNS Portion
<b>CLIENT SERVICES</b>							
Baker Places, Inc. Residential treatment			491,059		491,059	20%	98,212
Bayview-Hunter's Point Fdn. Methadone maintenance		152,000			315,870	100%	315,870
Street outreach			111,870				
Outpatient services			52,000				
DPH/Forensic Services Jail education			28,144		28,144	53%	14,916
18th Street Services Street Outreach		142,400			237,238	18%	42,703
Outpatient services		94,838					
PPMC/Operation Concern Outpatient services		60,000			60,000	15%	9,000
SFGH/PACE Methadone maintenance		39,720			39,720	51%	20,257
UCSF/AIDS Health Project Consultations	27,131				27,131	15%	4,070
Westside Community Mental Hlth Detox for non methadone		114,573			114,573	81%	92,804
Y.E.S. Street outreach/IVDUs		132,000	109,544	100,000	394,809	45%	177,664
Training			53,265				
<b>ADMINISTRATION/COORDINATION</b>							
Needs Assessment John Hayes			10,756		10,756	50%	5,378
Coordination DPH AIDS Office			66,292		129,934	45%	58,470
Bayview-Hunters Point Fdn.			10,068				
Youth Environment Studies			53,574				

PROGRAM/Provider	CITY BUDGET	[Grants to CCSF from] STATE	FEDERAL	KNOWN OTHER	TOTAL CONFIRMED	MINORITY Percent	CONCERNS Portion
-----							
CCSF CONTROLLER							
-----							
Indirects			44,677		44,677		
-----							
TOTALS	\$27,131	\$735,531	\$1,031,249	\$100,000	\$1,893,911	44%	\$839,344

-----

NOTE: "KNOWN OTHER" in this instance includes a \$100,000 grant direct to provider from California DHS.

=====

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FUNDING DISTRIBUTION FOR AIDS-RELATED ADMINISTRATIVE SUPPORT AND COORDINATION IN SAN FRANCISCO  
 CONFIRMED AT 02/29/88 FOR FISCAL YEAR 1987-1988

PROGRAM/Provider	CITY BUDGET	[Grants to CCSF from]		KNOWN OTHER	TOTAL CONFIRMED
		STATE	FEDERAL		
DPH/AIDS Office	539,835				539,835
DPH/Central Office (est. in-kind)	284,974				284,974
TOTALS	\$824,809	\$0	\$0	\$0	\$824,809

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## XVI. PROJECTED DIMENSIONS OF THE EPIDEMIC IN SAN FRANCISCO

This chapter provides an overview of the projections of AIDS cases, deaths, and number of people living with AIDS from 1988-1993. These projections are analyzed by various demographic factors such as risk-group, age, sex, and race/ethnicity. The methods used to establish these numbers are the result of a collaborative effort between researchers and epidemiologists from various disciplines and institutions in San Francisco and the Bay Area. They provide the foundation for examining the demand AIDS will place on our health care system and on society in the next five years.

### A. SUMMARY OF METHODS UTILIZED

Annual HIV seroconversion rates were combined for homosexual and bisexual men and for heterosexual IV drug users in San Francisco with estimates of the cumulative proportion with AIDS by duration of HIV infection, and with estimates of the size of the at-risk populations. These figures are explained in further detail in the chapter on the current dimensions of the epidemic (Chapter I). The data have been used to build an epidemic model for predicting AIDS morbidity in San Francisco through June 1993. Other components of the model have been extrapolated using weighted linear regressions of trends for AIDS. These trends were obtained from San Francisco surveillance data and from ratios of secondary transmission from IV drug users to their partners and/or children that were extrapolated from surveillance data from New York City, which has had much more experience with this latter transmission category.

AIDS mortality has been projected by applying Kaplan-Meier survival time estimates obtained from surveillance data to the projected numbers of cases diagnosed per month. Ranges on the forecasts have been calculated by using current and projected estimates of two key elements of the model; time for progression to AIDS and survival time after diagnosis.

San Francisco City Clinic Cohort Study estimates of the cumulative proportion with AIDS after 8 years of infection were extrapolated to 16 years by fitting linear and polynomial curves to the actual data points. These extrapolations yielded estimates of 65% to 100% progression to AIDS after 16 years of infection (Figure 1).

Figure 2 shows the survival following AIDS diagnosis for 3,661 patients whose diagnoses were reported in San Francisco between July 1981 and August 31, 1987. The median survival was 12.1 months, with 11% surviving more than three years.

Table 1 shows median survival by year of AIDS diagnosis, with cases diagnosed in each year analyzed as separate cohorts and followed to the present. Median survival remained relatively constant between 1981 and 1985,



ranging from 10 to 12 months. When developing the forecast it was assumed that survival would continue to lengthen in future years. The length of survival after an AIDS diagnosis could range from between the current median of 14.4 months to a "projected" median of 22 months.

Models of the epidemic curve were compared to the actual incidence of AIDS between 1980 and 1987. There was a high correlation between the observed and predicted epidemic curves ( $R^2 = 0.99$ ;  $p > 0.001$ ) (Figure 3).

## B. OVERALL PROJECTIONS FOR SAN FRANCISCO

Tables 2, 3, and 4 give the projected number of AIDS cases, living persons with AIDS, and deaths from AIDS by fiscal year for San Francisco through June 1993. The model predicts that 12,349 to 17,022 cumulative cases of AIDS will be diagnosed in San Francisco as of June 30, 1993 and between 9,966 and 12,767 cumulative deaths, leaving 4,255 people living with AIDS (ranging from 2,383 to 6,288) by this date. These projections include calculations of current and anticipated effects of antiviral therapy and other treatments on AIDS patient survival. Should an effective vaccine be developed or treatments become available that significantly slow the progression of HIV infection to AIDS, these projections may no longer be applicable.

## C. PROJECTIONS BY RISK GROUP

Figure 4 shows the projected AIDS incidence by risk group from fiscal years 1980 to 1993. Although cases for risk groups other than homosexual/bisexual males will increase disproportionately through 1993, the large majority of AIDS cases in San Francisco will continue to be homosexual and bisexual males. Tables 5 through 11 give the projected AIDS cases (living and dead) by risk group through June 30, 1993. Cumulative cases projected by risk group are:

1. Homosexual/bisexual males (non-IVDUs):	10,332 - 14,420
2. Homosexual/bisexual males (IVDU):	995 - 1,261
3. Heterosexual IVDUs:	531 - 612
4. Heterosexual partners of IVDUs:	35 - 41
5. Children of IVDUs:	30 - 34
6. Other non-IVDU-related adults:	382 - 571
7. Other non-IVDU-related children:	45 - 65

Tables 12 through 18 give the number of living persons with AIDS by fiscal year and by risk group.

D. PROJECTIONS FOR MEN, WOMEN, AND CHILDREN

Tables 19 through 21 give the projected AIDS cases (living and dead) for men, women, and children by fiscal year through June 1993. A cumulative total of 12,025 to 16,607 men, 249 to 316 women, and 75 to 99 children with AIDS are projected in San Francisco at the end of these five years.

Tables 22 through 24 give the number of living men, women, and children with AIDS by fiscal year.

E. PROJECTIONS BY RACE/ETHNICITY

Figure 5 shows the projected AIDS incidence by race/ethnicity for fiscal years 1980 to 1993. Although cases among minorities will increase disproportionately through 1993, the majority of AIDS cases will continue to be among whites.

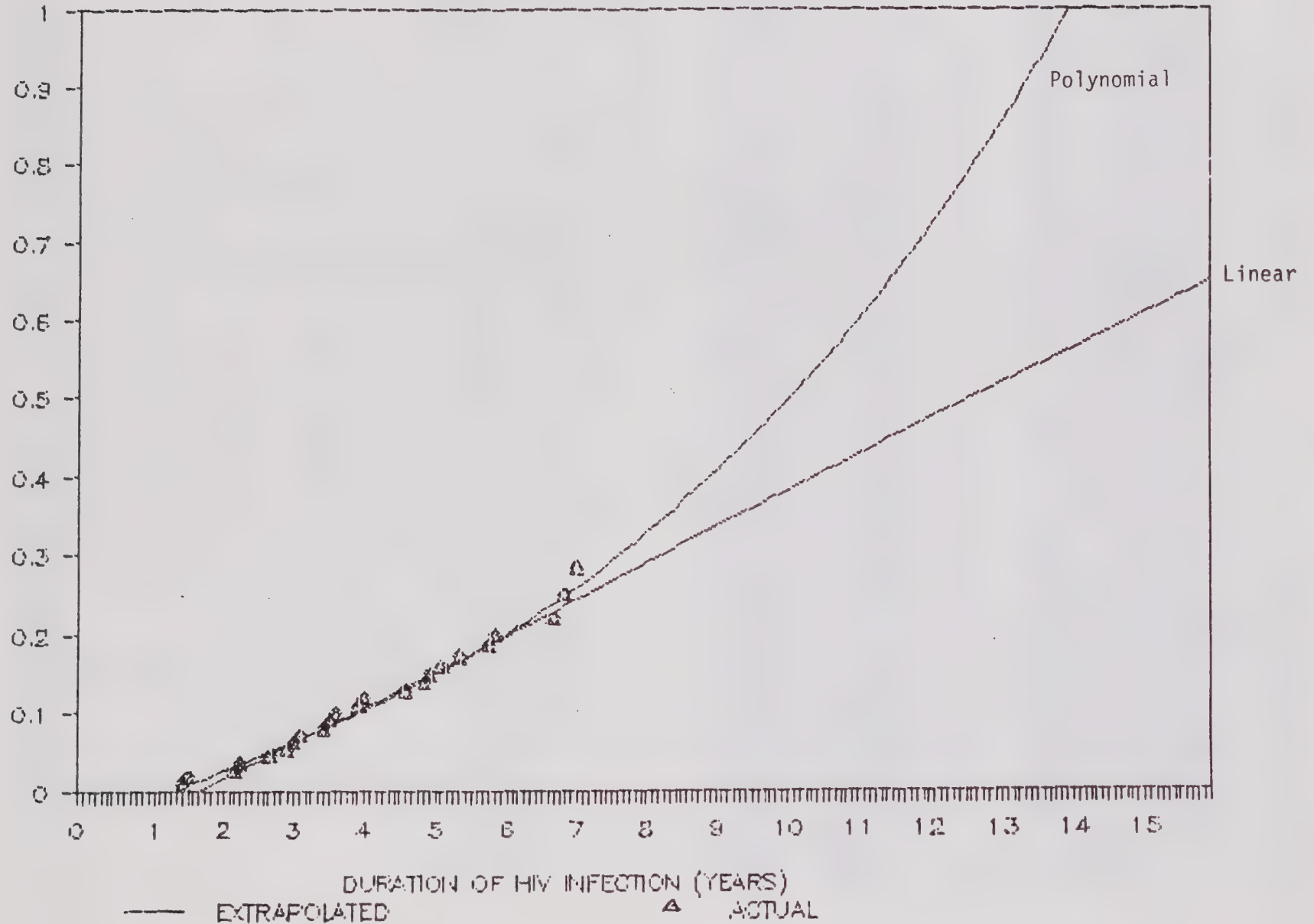
Tables 25 through 29 give the projected AIDS cases (living and dead) by race/ethnicity through June 1993, and Tables 30 through 34 give the number of living persons with AIDS by fiscal year and by race/ethnicity.

Figure 1

# Cumulative Proportion with AIDS

Hepatitis B Vaccine Trial Participants

CUMULATIVE PROPORTION WITH AIDS

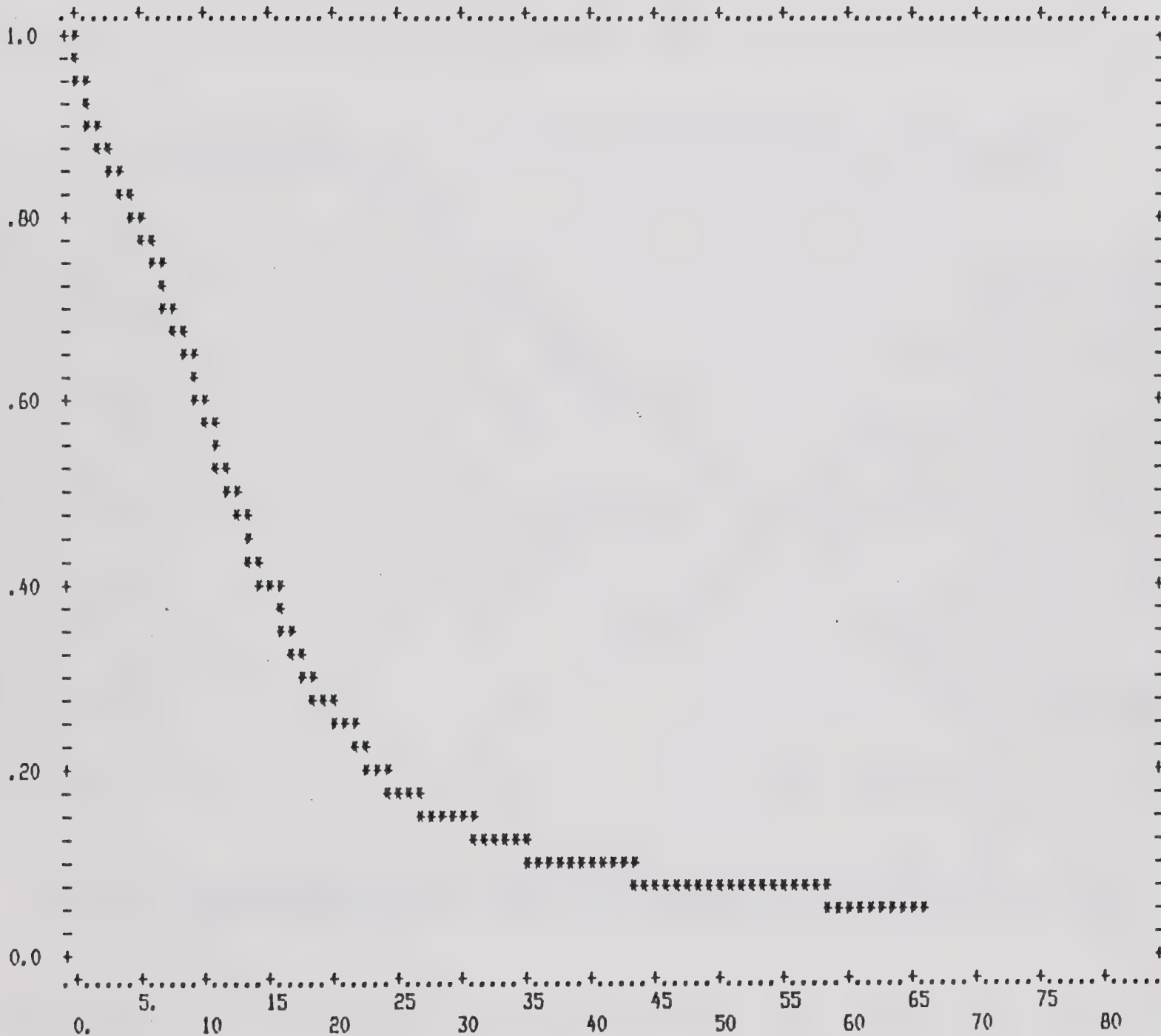




# SURVIVAL FOR SAN FRANCISCO AIDS CASES

Figure 2

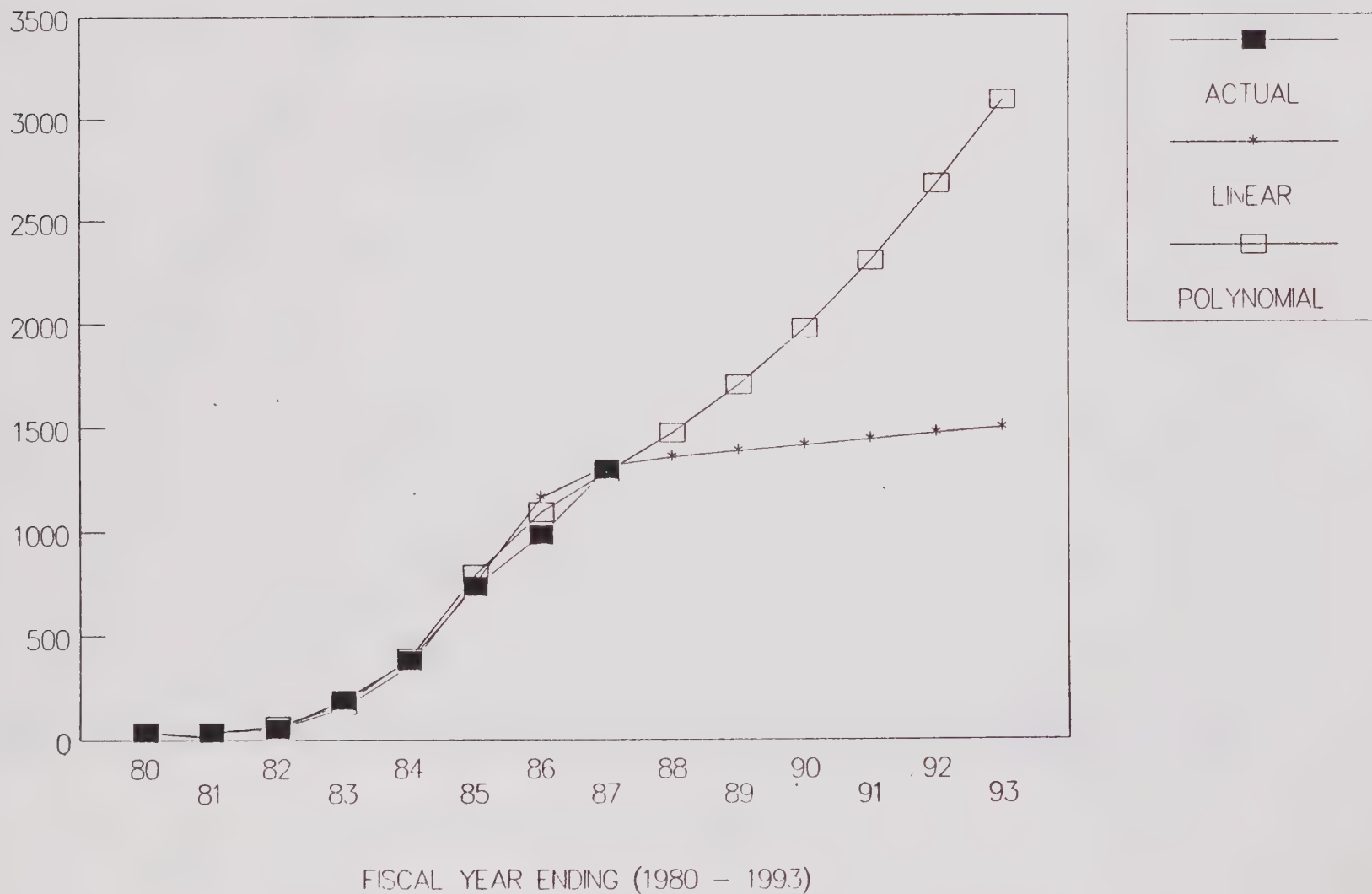
CUMULATIVE PROPORTION SURVIVING



MONTHS AFTER DIAGNOSIS

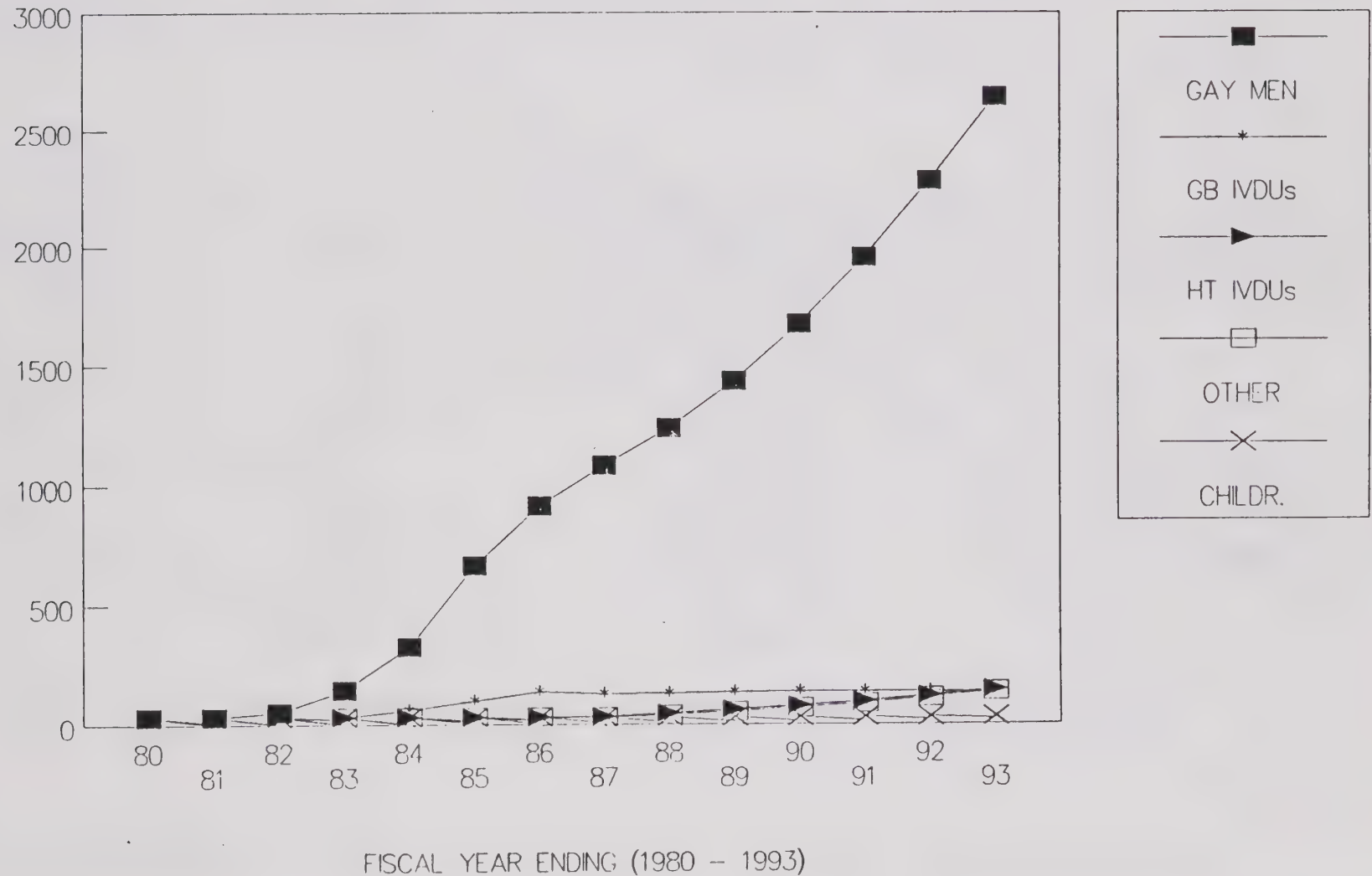
# PROJECTED AIDS INCIDENCE BY FISCAL YEAR

SAN FRANCISCO, JUNE 1980 – JUNE 1993



## PROJECTED AIDS INCIDENCE BY RISK GROUP

By Fiscal Year, S.F., Polynomial Model





# PROJECTED AIDS CASES BY RACE/ETHNICITY

Figure 5

By Fiscal Year, S.F., Polynomial Model

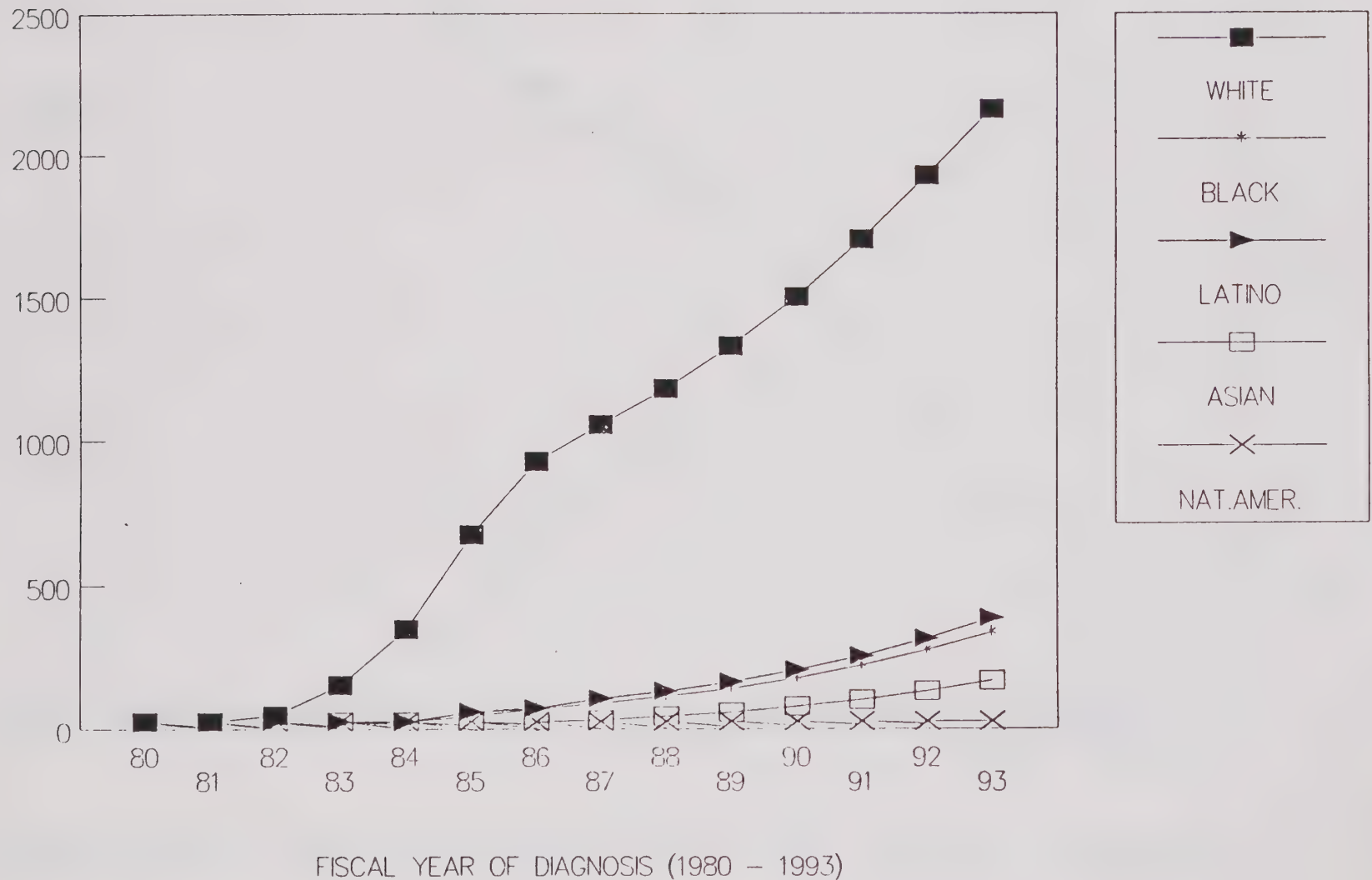


TABLE 1

Survival by Year of Diagnosis for San Francisco  
AIDS Cases Diagnosed through Aug. 31, 1987

<u>Year of Diagnosis</u>	<u>N</u>	<u>Median Survival (In Months)</u>	<u>P Value</u>
1981	25	10.2	< 0.01
1982	100	12.5	
1983	278	11.2	
1984	532	10.8	
1985	790	10.7	
1986	1121	14.4	

TABLE 2

## PROJECTED AIDS CASES IN SAN FRANCISCO BY FISCAL YEAR

FISCAL YEAR ENDING (TO 6/30)	ACTUAL CASES (CUMUL.*)	PROJECTED NUMBER OF AIDS CASES (RANGE)			
		LOWER RANGE		UPPER RANGE	
		CUMUL.*	ANNUAL**	CUMUL.*	ANNUAL**
1980	0				
1981	10				
1982	63				
1983	253				
1984	634				
1985	1371				
1986	2353				
1987	3648				
1988		5152	1355	5281	1471
1989		6536	1384	6983	1702
1990		7947	1411	8957	1974
1991		9386	1439	11258	2301
1992		10854	1468	13934	2676
1993		12349	1495	17022	3088

\* Cumulative cases since 1981

\*\* Cases diagnosed during the fiscal year



TABLE 3

PROJECTED NUMBER OF AIDS PATIENTS ALIVE IN S.F.  
AT THE END OF THE FISCAL YEAR (TO JUNE 30,1993)

FISCAL YEAR ENDING (TO 6/30)	ACTUAL NUMBER ALIVE (ON 6/30)	PROJECTED NUMBER ALIVE (RANGE)		
		LOWER ESTIMATE	MIDDLE ESTIMATE	UPPER ESTIMATE
1980	0			
1981	9			
1982	45			
1983	172			
1984	355			
1985	680			
1986	1031			
1987	1500			
1988		1814*	1889	2660
1989		1954	2237	3201
1990		2074	2637	3811
1991		2178	3104	4522
1992		2276	3645	5348
1993		2383	4255	6288

\* Projected Number Alive on June 30, 1988

TABLE 4

## ACTUAL AND PROJECTED AIDS DEATHS IN S.F. BY FISCAL YEAR (1980-1993)

FISCAL YEAR ENDING (TO 6/30)	ACTUAL DEATHS CUMUL.*	PROJECTED DEATHS FOR SF BY FISCAL YEAR (RANGE)			
		LOWER RANGE CUMUL.	ANNUAL	UPPER RANGE CUMUL.	ANNUAL
1980	0				
1981	1				
1982	18				
1983	81				
1984	279				
1985	691				
1986	1322				
1987	2148				
1988		3338	1139	3392	1145
1989		4582	1244	4746	1354
1990		5873	1291	6320	1574
1991		7208	1335	8154	1834
1992		8578	1370	10289	2135
1993		9966	1388	12767	2478

\* Cumulative AIDS deaths since 1981

TABLE 5

PROJECTED HOMOSEXUAL/BISEXUAL NON-IVDU AIDS CASES  
(RANGE) BY FISCAL YEAR

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	4342	1136	4434	1239
1989	5498	1156	5869	1435
1990	6675	1177	7541	1672
1991	7873	1198	9495	1954
1992	9092	1219	11777	2282
1993	10332	1240	14420	2643

\* Cumulative cases since 1981.

TABLE 6

PROJECTED HOMOSEXUAL/BISEXUAL IVDUs WITH AIDS  
BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	570	121	582	132
1989	679	109	717	135
1990	776	97	855	138
1991	861	85	994	139
1992	934	73	1131	137
1993	995	61	1261	130

\* Cumulative cases since 1981.



TABLE 7

## PROJECTED HETEROSEXUAL IVDU AIDS CASES IN SF BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	108	49	110	47
1989	170	62	173	63
1990	243	73	251	78
1991	328	85	349	98
1992	424	96	468	119
1993	531	107	612	144

\* Cumulative cases since 1981.

TABLE 8

PROJECTED AIDS CASES AMONG CHILDREN OF IVDUS IN  
SF BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	6	3	6	3
1989	10	3	10	3
1990	14	4	14	4
1991	18	5	20	6
1992	24	5	26	7
1993	30	6	34	8

\* Cumulative cases since 1981

TABLE 9

PROJECTED AIDS CASES AMONG HETEROSEXUAL CONTACT PARTNERS OF  
IVDUs IN SF BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	7	3	7	3
1989	11	4	12	4
1990	16	5	17	5
1991	22	6	23	7
1992	28	6	31	8
1993	35	7	41	10

\* Cumulative cases since 1981.

TABLE 10

PROJECTED AIDS CASES AMONG OTHER NON-IVDU-RELATED ADULTS & ADOLESCENTS  
BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	107	38	110	41
1989	150	43	163	53
1990	199	49	232	69
1991	254	55	320	88
1992	315	61	432	112
1993	382	67	571	139

\* Cumulative cases since 1981.

TABLE 11

PROJECTED AIDS CASES AMONG OTHER NON-IVDU-RELATED CHILDREN (0-12 yrs)  
BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	13	5	14	6
1989	19	6	21	7
1990	25	6	29	8
1991	31	6	39	10
1992	38	7	51	12
1993	45	7	65	14

\* Cumulative cases since 1981.

TABLE 12

PROJECTED GAY & BISEXUAL MALES (NON-IVDUs) ALIVE WITH AIDS  
AT THE END OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	1526	1584	2230
1989	1637	1884	2693
1990	1730	2222	3209
1991	1816	2626	3821
1992	1901	3095	4535
1993	1978	3628	5352



TABLE 13

PROJECTED GAY/BISEXUAL IVDUs ALIVE WITH AIDS  
AT THE END OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	178	185	270
1989	172	194	289
1990	163	210	315
1991	153	220	337
1992	141	219	346
1993	129	222	356

TABLE 14

PROJECTED HETEROSEXUAL IVDUs ALIVE WITH AIDS  
AT THE END OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	53	55	73
1989	71	72	99
1990	90	99	137
1991	108	123	172
1992	128	153	217
1993	147	187	268

TABLE 15

PROJECTED CHILDREN OF IVDUs ALIVE WITH AIDS  
AT THE END OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	3	3	4
1989	4	4	5
1990	5	5	7
1991	6	7	9
1992	7	9	12
1993	8	10	14

TABLE 16

PROJECTED HETEROSEXUAL CONTACT PARTNERS OF IVDUs ALIVE WITH AIDS  
AT THE END OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	3	3	4
1989	5	5	6
1990	6	6	8
1991	8	8	11
1992	8	10	14
1993	10	13	18

TABLE 17

PROJECTED OTHER NON-IVDU-RELATED ADULTS & ADOLESCENTS ALIVE WITH AIDS  
AT THE END OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	46	46	63
1989	59	59	82
1990	66	84	115
1991	79	106	148
1992	86	135	191
1993	99	178	251

TABLE 18

PROJECTED OTHER NON-IVDU-RELATED CHILDREN (0-12 yrs) ALIVE WITH AIDS  
AT THE END OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	6	6	8
1989	7	8	11
1990	8	10	14
1991	9	13	18
1992	10	16	22
1993	11	19	27



TABLE 19

PROJECTED AIDS CASES AMONG CHILDREN (0-12 yrs)  
BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	19	8	20	9
1989	29	9	31	10
1990	39	10	43	12
1991	49	11	59	16
1992	62	12	77	19
1993	75	13	99	22

\* Cumulative cases since 1981.

TABLE 20

PROJECTED FEMALE ADULT/ADOLESCENT AIDS CASES IN SF  
BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	57	24	58	24
1989	86	29	89	31
1990	120	34	129	40
1991	157	37	179	50
1992	201	44	241	62
1993	249	48	316	75

\* Cumulative cases since 1981.

TABLE 21

PROJECTED MALE ADULT/ADOLESCENT AIDS CASES IN SF  
BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	5076	1323	5203	1438
1989	6421	1345	6863	1660
1990	7788	1367	8785	1922
1991	9180	1392	11020	2235
1992	10591	1411	13616	2596
1993	12025	1434	16607	2991

\* Cumulative cases since 1981.

TABLE 22

PROJECTED ADULT/ADOLESCENT MALES ALIVE WITH AIDS  
AT THE END OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	1775	1850	2608
1989	1908	2181	3126
1990	2015	2564	3711
1991	2111	3014	4394
1992	2206	3536	5192
1993	2301	4127	6102

TABLE 23.

PROJECTED ADULT/ADOLESCENT FEMALES ALIVE WITH AIDS  
AT THE END OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	26	26	34
1989	31	40	53
1990	43	47	66
1991	49	60	85
1992	61	76	107
1993	68	93	133

TABLE 24

PROJECTED CHILDREN (0-12 yrs) ALIVE WITH AIDS  
AT THE END OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	9	10	13
1989	12	13	17
1990	13	15	22
1991	15	20	28
1992	17	23	33
1993	19	28	41



TABLE 25

PROJECTED WHITE AIDS CASES IN SF  
BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	4297	1084	4387	1177
1989	5376	1079	5714	1327
1990	6448	1072	7214	1500
1991	7512	1064	8916	1702
1992	8568	1056	10842	1926
1993	9614	1046	13002	2160

\* Cumulative cases since 1981

TABLE 26

PROJECTED BLACK AIDS CASES IN SF  
BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	345	105	352	114
1989	461	116	494	142
1990	588	127	671	177
1991	726	138	892	221
1992	876	150	1166	274
1993	1038	162	1501	335

\* Cumulative Cases since 1981.

TABLE 27

PROJECTED LATINO AIDS CASES IN SF  
BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	398	122	408	132
1989	532	134	573	165
1990	678	146	778	205
1991	837	159	1032	254
1992	1009	172	1346	314
1993	1195	186	1730	384

\* Cumulative cases since 1981.

TABLE 28

PROJECTED ASIAN AIDS CASES IN SF  
BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	108	40	110	44
1989	156	48	169	59
1990	212	56	247	78
1991	276	64	349	102
1992	348	72	481	132
1993	429	81	649	168

\* Cumulative cases since 1981.

TABLE 29

PROJECTED NATIVE AMERICAN AIDS CASES IN SF  
BY FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOWER RANGE		UPPER RANGE	
	CUMUL.*	ANNUAL	CUMUL.	ANNUAL
1988	8	4	8	4
1989	14	6	15	7
1990	21	7	25	10
1991	30	9	39	14
1992	40	10	58	19
1993	52	12	83	25

\* Cumulative cases since 1981.

TABLE 30

PROJECTED WHITES ALIVE WITH AIDS AT THE END  
OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	1475	1534	2174
1989	1559	1779	2564
1990	1611	2045	2981
1991	1659	2350	3458
1992	1697	2698	4001
1993	1731	3069	4592



TABLE 31

PROJECTED BLACKS ALIVE WITH AIDS AT THE END  
OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	135	144	198
1989	158	181	253
1990	180	227	320
1991	201	279	397
1992	223	351	502
1993	246	436	626

TABLE 32

PROJECTED LATINOS ALIVE WITH AIDS AT THE END  
OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	152	160	220
1989	176	206	288
1990	198	258	364
1991	220	322	458
1992	242	401	573
1993	274	498	715

TABLE 33

PROJECTED ASIANS ALIVE WITH AIDS AT THE END  
OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	46	53	69
1989	59	71	97
1990	75	98	135
1991	83	131	181
1992	97	166	233
1993	114	211	298

TABLE 34

PROJECTED NATIVE AMERICANS ALIVE WITH AIDS AT THE END  
OF THE FISCAL YEAR (RANGE)

FISCAL YEAR ENDING	LOW	MID.	HIGH
1988	4	4	5
1989	6	7	9
1990	8	11	15
1991	11	16	22
1992	13	22	31
1993	16	30	42





XVII. PROJECTIONS OF SERVICE NEEDS FOR 1988-93

Under the best of circumstances, projections of AIDS service needs are speculative. Even though San Francisco has assembled more data about AIDS-related services than most communities, the diversity of service categories and the softness of much of the data currently available makes projecting the need for various services particularly difficult.

The main purpose of this chapter is to outline (with light lines) a picture of what probably lies ahead for AIDS services in San Francisco, given what we know today. It is also our purpose to establish a starting point and general framework for future discussions of service needs. It is not our intent that the numbers reflected in the following charts should be regarded as unalterable. In addition, readers should note that the information presented here does not reflect any effort to prioritize the service needs described or to identify potential payors for any given service.

Above all, the discussion that follows should not be regarded as the preamble to a definitive spending plan for the next five years. Many of the specifics suggested here could easily be altered by such circumstances as the development of an effective AIDS vaccine or changes in the epidemiology of the epidemic, or by a more sophisticated analysis of the numbers.

What seems irrefutable, however, is the observation that San Francisco has not yet experienced the full weight of the AIDS epidemic. Whatever happens over the next five years and however the current continuum of services is molded in response, coping with AIDS will continue to dominate our public health concerns and health care delivery system for some time to come. AIDS will continue to debilitate and take lives, drain our financial and emotional resources, tax our intelligence and skills, and test our compassion and humanity.

Background

For purposes of this report, projections are grouped into four categories:

- (1) Services for which utilization and demand are in direct proportion to the number of persons living with AIDS at the time AND for which there is a commonly agreed upon unit of service, a relatively accurate measure of current utilization/demand, and a reliable estimate of the cost per unit.
- (2) Services for which utilization and demand are in direct proportion to the number of persons living with AIDS at the time BUT for which there is no commonly agreed upon unit of service or there is no accurate measure of current utilization. In these instances, the projections are shown as overall budget increases (which factor in inflation and accommodate the growth in the number of living

persons with AIDS) without reference to specific counts of units of service. The financial implications of this approach are exactly the same as those in (1) above. What is missing is an indication of the units of service being provided.

- (3) Services for which demand at any given time is NOT directly related to the number of persons living with AIDS. In these instances, the projections are shown as overall budget increases which factor in inflation alone. Most education and prevention services fall into this category, as do epidemiologic studies, community surveys, and related research. For purposes of this particular report, it is assumed that new activities in these areas can and will be undertaken with internally redirected resources. If additional resources are required, it is further assumed that they will be secured from some sources other than City/County government.
- (4) Services for which demand is related to some predictable variable other than the number of persons living with AIDS at the time. In this report, AIDS surveillance activities are the only services in this category. The demand for these services is a function of the number of new AIDS cases reported during the period rather than the number living.

At the end of December 1987, there were 1,706 living persons with AIDS in San Francisco. As discussed in (1) and (2) above, this number has been used as the basis for quantifying the relationship between services provided in 1987-88 and living PWAs at a point in time.

For most services, it is assumed that current capacities relative to the number living with AIDS approximate optimal configurations. In some instances, however, we are anticipating a change in the basic pattern of service needs, and this base number of 1,706 is incorporated into our description of the shift to something closer to "optimal" capacity or utilization of each category of service. When a shift in the existing pattern is proposed, it is based on one or more of the following:

- (a) Surveys of current providers suggest that utilization might be different in some instances if alternative services were more fully developed. For example, if day care programs were available for PWAs in 1987-88, we assume they would have an impact on the pattern of home care utilization, utilization of acute care facilities, mental health, housing, and related support services.
- (b) Anecdotal evidence also indicates that the needs of some persons with AIDS or ARC are not being met by the current configuration of programs. For example, a Departmental committee has identified a critical shortage of housing resources for persons with AIDS/ARC.
- (c) Certain designated care settings are shown to be capped at a particular service level after 1987-88. It is assumed that general demand beyond these caps will be absorbed by some other setting. For example, we project that inpatient hospital care for persons

with AIDS/ARC at San Francisco General Hospital will level off at a daily inpatient census of 35, and that growth related to the increase in numbers of cases will be absorbed by community hospitals. Such caps are not cemented in place, by any means.

An overview of the services for which departures from the present pattern of utilization are expected is presented as Group 1 below. All numbers given reflect the current situation: i.e. all can be related to the 1,706 persons living with AIDS at the end of December 1987 (halfway through the 1987-88 fiscal cycle).





GROUP (1): FOR WHICH RELATIVELY ACCURATE MEASURES OF NEED AND COST EXIST

<u>SERVICE/Unit of service</u>	<u>CURRENT CAPACITY/UTILIZATION</u>	
	<u>YEAR</u>	<u>DAY</u>
OUTPATIENT SERVICES AT SFGH/AFFILIATES		
Encounters	27,165	74

Projections assume that after 1987-88 there will be a very gradual shifting of the burden of primary care away from SFGH and affiliated clinics. This will be relative to the number of persons living with AIDS and is not expected to show up as an absolute reduction in demand. It parallels somewhat the shift shown for inpatient care.

OUTPATIENT SERVICES IN PRIMARY CARE SETTINGS NOT FUNDED BY DPH		
Encounters	88,593	243

This assumes that the division of AIDS primary care between county-affiliated clinical services and other primary care settings parallels that of inpatient care between SFGH and other hospitals in San Francisco. It has been documented that 29% of AIDS inpatient care for San Franciscans is provided by SFGH and it is estimated that all county-affiliated clinical services (at SFGH and other DPH clinics) will log 35,641 AIDS-related outpatient encounters in 1987-88. The "plug" figure shown here represents the balance of the 124,234 total encounters extrapolated from these base numbers. In our projections, the average charge per encounter equals that used in the SFGH calculation. It, too, is a "plug".

ACUTE INPATIENT CARE AT SFGH		
Patient days	12,775	35

The projections assume that the average daily census at SFGH will remain at 35 and that the expanding demand for inpatient care will be absorbed by community hospitals.

ACUTE INPATIENT CARE AT OTHER HOSPITALS		
Patient days	31,923	87

The projections assume that 7.15% of the number living with AIDS at any given time will require acute inpatient care and that all those above the 35 at SFGH will be accommodated at other community hospitals.

SERVICE/Unit of service	CURRENT CAPACITY/UTILIZATION	
	YEAR	DAY
SUBACUTE CARE		
Patient days	1,095	3

The service configuration described in this report includes three general levels of post-acute institutional care: subacute, intermediate, and skilled nursing. The distinctions are not particularly refined at this point. They are maintained in this instance because there are known differences in cost/reimbursement levels associated with each. The projections assume a constant relationship between the number in this highest level of post-acute care and the number living with AIDS.

INTERMEDIATE CARE		
Patient days	1,425	4

Anecdotal evidence suggests that, of current AIDS/ARC patients, an additional 3 would be better accommodated at this level of care.

SKILLED NURSING CARE		
Patient days	8,395	23

Estimates vary dramatically regarding the demand for skilled nursing care. The most persuasive at this point suggest that an additional 30 should be receiving some level of institutional nursing care.

HOME HEALTH AND HOSPICE CARE		
Patient days	29,200	80

The projections do not reflect home health care services that are less intensive than those provided by DPH's contractor, Visiting Nurses and Hospice of San Francisco (HSF). It is estimated that as many as 100 persons with AIDS/ARC over the 80 accounted for by HSF are receiving some level of home care, but there are no data currently available on the intensity of that care or its cost. It is assumed that many of the 100 could be accommodated in an adult day care program for persons with AIDS/ARC, if such a program were operating.

EMERGENCY HOUSING		
Resident days	2,518	7

The need for additional housing resources is acknowledged to be great. It is assumed, however, that the demand for emergency housing, per se, would remain at 7 persons per day if other programs were adequately developed. The projections for "other housing support" are designed to accommodate this unmet need.



<u>SERVICE/Unit of service</u>	<u>CURRENT CAPACITY/UTILIZATION</u>	
	<u>YEAR</u>	<u>DAY</u>
LONG TERM INDEPENDENT HOUSING		
Resident days	17,000	47
Projections for this type of housing also assume no increase in these particular services.		
OTHER HOUSING SUPPORT		
Resident days	14,600	40
The figures provided here indicate the caseload of a service designed to provide advocacy and in-residence support for individuals with AIDS/ARC living in a housing program staffed 24-hours a day. The funding associated with these services does <u>not</u> cover the cost of housing itself. It is conservatively estimated that, even if all other AIDS-related housing services are operating at budgeted capacity, an <u>additional 85 persons</u> with AIDS/ARC are homeless or in temporary housing which further compromises their health. The projections accommodate this additional number in this category.		
ASSISTANCE WITH DAILY LIVING		
Contact hours	63,000	173
It is assumed that the pattern of demand will remain constant relative to the number living with AIDS.		
FOOD BANK		
Bags of groceries	7,388	20
It is assumed that the pattern of demand will remain constant relative to the number living with AIDS.		
MEALS DELIVERY		
Meals delivered	127,000	348
It is assumed that the pattern of demand will remain constant relative to the number living with AIDS.		
SOCIAL SERVICE ADVOCACY		
Clients served	1,600	N/A
It is assumed that the pattern of demand will remain constant relative to the number living with AIDS.		

<u>SERVICE/Unit of service</u>	<u>CURRENT CAPACITY/UTILIZATION</u>	
	<u>YEAR</u>	<u>DAY</u>
<b>ASSESSMENTS AND CASE MANAGEMENT</b>		
Clients served	130	N/A

In-home assessments are currently provided by Public Health Nurses. California DHS anticipates requiring case management of all persons with AIDS/ARC receiving out-of-hospital services to be reimbursed under the MediCal waiver discussed earlier in this report. PHNs will serve as case managers. Projections have been developed on the assumption that, of the 700 cases MediCal will allow to participate in the waiver program statewide, 280 will be in San Francisco.

#### DAY CARE SERVICES

Client days	-0-	-0-
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These services are not currently in place as AIDS-specific services, although a few clients of community mental health services' day care programs are known to be AIDS-affected. Projections for 1988-89 assume that 72 (4.2% of 1,706) currently need daycare services. Most are at home and receiving some licensed home care or receiving no care other than that provided by their personal support systems. The base cost reflected in the projections is the per diem cost of geriatric day treatment in Community Mental Health Services.

#### GROUP (2): OTHER SERVICES VARYING WITH NUMBERS OF LIVING PERSONS WITH AIDS

There are several groups of activities reflected in the 1987-88 budgets associated with this report which are not readily described in terms of a unit of service and a cost per unit. In some cases they could, theoretically, be so described, but a reliable count is not currently available. In other cases, there are various units of service and the budgets available are not broken down in terms of those units. Of the activities which fall into this group, several address needs which are arguably part of a pattern which will remain constant relative to the number living with AIDS. These services and activities are the following:

#### OUTPATIENT SERVICES OF DPH CLINICS NOT AFFILIATED WITH SFGH

AIDS-specific budgets are available for many of these services but reliable counts of AIDS-specific activity are not. It is clear, however, that the demand will grow with the number of living persons.

#### FEDERAL AZT PROGRAM

Presumably one-time Federal funding was made available in FY 1987-88 to provide AZT for people whose private insurance would not cover the costs of the drug or who were not MediCal eligible. While it is not yet known what the utilization of this program will be, there will certainly continue to be a demand for this drug as it is one of the few currently available. Should this Federal program be annualized, its utilization will continue to be a function of the number of people living with AIDS. The projections assume that it may continue in proportion to base established by the current funding level.

#### AIDS LEGAL EDUCATION AND DISCRIMINATION COMPLAINTS

These are activities related to educating persons with AIDS/ARC about their options, rights, and responsibilities. While reported complaints of discrimination against people because of their antibody or health status are actually down, it is expected that complaints against service providers will rise as AIDS-identified resources become more scarce and access becomes more restricted.

#### COORDINATION OF CHRONIC CARE, HOUSING, SUPPORT SERVICES

These are planning and program development functions whose responsibilities will increase as services increase. They are not, however, readily expressed in terms of service units.

#### MENTAL HEALTH SERVICES

These services involve a variety of unit counts (e.g. patient days, patient encounters, contact hours, residence days). Many of the services---particularly crisis intervention, outpatient treatment and emotional support---are provided not only to people with AIDS but also to individuals who are their significant others and care providers. Even so, it is expected that needs will grow in proportion to the increase in numbers of persons living with AIDS.

#### SUBSTANCE ABUSE TREATMENT FOR PWAs/ARC ALSO NEEDING HEALTH CARE

These are also services which involve a variety of unit counts. They are distinct from AIDS prevention services which are associated with substance abuse prevention and treatment programs.



## ADMINISTRATIVE SUPPORT AND COORDINATION

These activities are associated with coordination of the overall AIDS effort in San Francisco (including all eight service areas discussed in this report). They are distinct from those associated with specific areas of service but are, by and large, variable depending on the number of persons living with AIDS. The need for such support and coordination will also expand as resources become tighter and funding options more distant.

### GROUP (3): WHOSE COSTS ARE NOT EXPECTED TO VARY WITH THE NUMBER LIVING WITH AIDS

The needs for programs included in this group may well expand over time. If so, however, some factor other than the number of persons living with AIDS will probably determine the extent of the expansion. This group encompasses:

EPIDEMIOLOGY, SURVEYS, AND RELATED RESEARCH

PUBLIC EDUCATION

PROVIDER EDUCATION AND STAFF SUPPORT

ASSESSMENTS OF NEED FOR CHRONIC CARE, ETC.

These assessments were directly funded by the California Department of Health Services in 1987-88. It is assumed that some assessment activity will be needed each year for the next five years, even though the focus may be some other category of services.

### SUBSTANCE ABUSE-SPECIFIC AIDS PREVENTION

In the earlier chapter on AIDS and substance abuse, the report discusses the intimate relationship between substance abuse and AIDS transmission. The observation is made that all substance abuse prevention and treatment programs are, in essence, also AIDS prevention programs. The projections reflected in the attached materials do not account for needed expansion of substance abuse prevention and treatment programs per se.

### GROUP (4): FOR WHICH DEMAND IS DETERMINED BY SOME OTHER VARIABLE

The relationship of AIDS SURVEILLANCE activities to the number of reported cases (distinct from the number of persons with AIDS living at any given time) has been discussed earlier. In the projections, the expansion of surveillance services is keyed to the number of AIDS cases anticipated for the period.

GROUP (1):

FOR WHICH RELATIVELY ACCURATE MEASURES OF NEED AND COST EXIST

NOTES:     \*Projections assume that the reference cost (whether unit cost or program budget) will increase by 5% per year.

          \*Other operative assumptions are discussed earlier in this chapter.

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
AIDS OUTPATIENT SERVICES AT SFGH AND SFGH-AFFILIATED CLINICS						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Encounters/#LwA	15.92	15.56	14.83	14.10	13.37	12.65
Encounters (units)	27,165	29,313	29,869	29,277	29,785	29,459
Unit cost	152.15	159.76	167.74	176.13	184.94	194.19
TOTAL LOW ESTIMATE	\$4,133,140	\$4,683,009	\$5,010,434	\$5,156,638	\$5,508,374	\$5,720,585
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Encounters/#LwA	15.92	15.56	14.83	14.10	13.37	12.65
Encounters (units)	27,165	32,098	36,143	40,482	45,132	49,953
Unit cost	\$152.15	\$159.76	\$167.74	\$176.13	\$184.94	\$194.19
TOTAL MIDDLE ESTIMATE	\$4,133,140	\$5,127,944	\$6,062,774	\$7,130,120	\$8,346,659	\$9,700,069
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Encounters/#LwA	15.92	15.56	14.83	14.10	13.37	12.65
Encounters (units)	27,165	45,596	51,997	58,759	66,003	73,576
Unit cost	\$152.15	\$159.76	\$167.74	\$176.13	\$184.94	\$194.19
TOTAL HIGH ESTIMATE	\$4,133,140	\$7,284,266	\$8,722,234	\$10,349,293	\$12,206,479	\$14,287,342

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## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
AIDS OUTPATIENT SERVICES IN SETTINGS NOT ASSOCIATED WITH DPH/SFGH BUDGETS*						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Encounters/#LWA	51.93	52.29	53.02	53.75	54.48	55.21
Encounters (units)	88,593	98,522	106,787	111,586	121,324	128,604
Unit cost	\$152.15	\$159.76	\$167.74	\$176.13	\$184.94	\$194.19
TOTAL LOW ESTIMATE	\$13,479,369	\$15,739,638	\$17,912,979	\$19,653,879	\$22,437,478	\$24,973,065
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Encounters/#LWA	51.93	52.29	53.02	53.75	54.48	55.21
Encounters (units)	88,593	107,883	129,216	154,291	183,838	218,067
Unit cost	\$152.15	\$159.76	\$167.74	\$176.13	\$184.94	\$194.19
TOTAL MIDDLE ESTIMATE	\$13,479,369	\$17,235,071	\$21,675,238	\$27,175,559	\$33,998,774	\$42,345,398
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Encounters/#LWA	51.93	52.29	53.02	53.75	54.48	55.21
Encounters (units)	88,593	153,248	185,896	223,951	268,852	321,193
Unit cost	\$152.15	\$159.76	\$167.74	\$176.13	\$184.94	\$194.19
TOTAL HIGH ESTIMATE	\$13,479,369	\$24,482,489	\$31,183,170	\$39,445,033	\$49,721,129	\$62,371,020

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## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
HOSPITAL INPATIENT CARE AT SF6H						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Patient days/#LWA	7.49	6.78	6.34	6.15	5.74	5.48
Patient days (units)	12,775	12,775	12,775	12,775	12,775	12,775
Unit cost	\$867.00	\$910.35	\$955.87	\$1,003.66	\$1,053.84	\$1,106.54
TOTAL LOW ESTIMATE	\$11,075,925	\$11,629,721	\$12,211,207	\$12,821,768	\$13,462,856	\$14,135,999
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Patient days/#LWA	7.49	6.19	5.24	4.45	3.79	3.23
Patient days (units)	12,775	12,775	12,775	12,775	12,775	12,775
Unit cost	\$867.00	\$910.35	\$955.87	\$1,003.66	\$1,053.84	\$1,106.54
TOTAL MIDDLE ESTIMATE	\$11,075,925	\$11,629,721	\$12,211,207	\$12,821,768	\$13,462,856	\$14,135,999
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Patient days/#LWA	7.49	4.36	3.64	3.07	2.59	2.20
Patient days (units)	12,775	12,775	12,775	12,775	12,775	12,775
Unit cost	\$867.00	\$910.35	\$955.87	\$1,003.66	\$1,053.84	\$1,106.54
TOTAL HIGH ESTIMATE	\$11,075,925	\$11,629,721	\$12,211,207	\$12,821,768	\$13,462,856	\$14,135,999

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## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
HOSPITAL INPATIENT CARE AT OTHER WEST BAY HOSPITALS						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Patient days/#LwA	18.71	19.42	19.86	20.05	20.46	20.72
Patient days (units)	31,923	36,587	39,993	41,617	45,573	48,259
Unit cost	\$983.00	\$1,032.15	\$1,083.76	\$1,137.95	\$1,194.84	\$1,254.58
TOTAL LOW ESTIMATE	\$31,380,193	\$37,762,811	\$43,342,286	\$47,357,907	\$54,452,911	\$60,544,796
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Patient days/#LwA	18.71	20.01	20.96	21.75	22.41	22.97
Patient days (units)	31,923	41,276	51,075	62,433	75,638	90,717
Unit cost	\$983.00	\$1,032.15	\$1,083.76	\$1,137.95	\$1,194.84	\$1,254.58
TOTAL MIDDLE ESTIMATE	\$31,380,193	\$42,603,462	\$55,353,321	\$71,045,626	\$90,375,806	\$113,811,640
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Patient days/#LwA	18.71	21.84	22.56	23.13	23.61	24.00
Patient days (units)	31,923	64,005	79,084	96,389	116,524	139,659
Unit cost	\$983.00	\$1,032.15	\$1,083.76	\$1,137.95	\$1,194.84	\$1,254.58
TOTAL HIGH ESTIMATE	\$31,380,193	\$66,063,042	\$85,707,447	\$109,685,379	\$139,227,813	\$175,213,964

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## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
SUBACUTE CARE						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Patient days/#LwA	0.64	0.64	0.64	0.64	0.64	0.64
Patient days (units)	1,095	1,209	1,293	1,332	1,429	1,495
Unit cost	\$497.00	\$521.85	\$547.94	\$575.34	\$604.11	\$634.31
TOTAL LOW ESTIMATE	\$544,215	\$631,047	\$708,320	\$766,632	\$863,513	\$948,420
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Patient days/#LwA	0.64	0.64	0.64	0.64	0.64	0.64
Patient days (units)	1,095	1,324	1,564	1,842	2,166	2,535
Unit cost	\$497.00	\$521.85	\$547.94	\$575.34	\$604.11	\$634.31
TOTAL MIDDLE ESTIMATE	\$544,215	\$691,003	\$857,088	\$1,060,027	\$1,308,453	\$1,608,182
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Patient days/#LwA	0.64	0.64	0.64	0.64	0.64	0.64
Patient days (units)	1,095	1,881	2,250	2,674	3,168	3,734
Unit cost	\$497.00	\$521.85	\$547.94	\$575.34	\$604.11	\$634.31
TOTAL HIGH ESTIMATE	\$544,215	\$981,573	\$1,233,054	\$1,538,618	\$1,913,532	\$2,368,709

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## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
INTERMEDIATE CARE						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Patient days/#LwA	0.84	1.50	1.50	1.50	1.50	1.50
Patient days (units)	1,425	2,820	3,015	3,108	3,334	3,487
Unit cost	\$312.06	\$327.66	\$344.04	\$361.25	\$379.31	\$398.28
TOTAL LOW ESTIMATE	\$444,684	\$924,121	\$1,037,281	\$1,122,674	\$1,264,550	\$1,388,889
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Patient days/#LwA	0.84	1.50	1.50	1.50	1.50	1.50
Patient days (units)	1,425	3,088	3,648	4,297	5,052	5,913
Unit cost	\$312.06	\$327.66	\$344.04	\$361.25	\$379.31	\$398.28
TOTAL MIDDLE ESTIMATE	\$444,684	\$1,011,922	\$1,255,141	\$1,552,329	\$1,916,130	\$2,355,060
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Patient days/#LwA	0.84	1.50	1.50	1.50	1.50	1.50
Patient days (units)	1,425	4,387	5,248	6,237	7,388	8,710
Unit cost	\$312.06	\$327.66	\$344.04	\$361.25	\$379.31	\$398.28
TOTAL HIGH ESTIMATE	\$444,684	\$1,437,439	\$1,805,714	\$2,253,190	\$2,802,224	\$3,468,795

BBPLAN.WK1  
A226..1270

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
<b>SKILLED NURSING</b>						
<b>Low Estimate</b>						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Patient days/\$LwA	4.92	11.34	11.34	11.34	11.34	11.34
Patient days (units)	8,395	21,359	22,833	23,536	25,247	26,410
Unit cost	\$151.98	\$159.58	\$167.56	\$175.94	\$184.73	\$193.97
<b>TOTAL LOW ESTIMATE</b>	<b>\$1,275,872</b>	<b>\$3,408,433</b>	<b>\$3,825,803</b>	<b>\$4,140,758</b>	<b>\$4,664,037</b>	<b>\$5,122,640</b>
<b>Middle Estimate</b>						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Patient days/\$LwA	4.92	11.34	11.34	11.34	11.34	11.34
Patient days (units)	8,395	23,388	27,628	32,543	38,257	44,781
Unit cost	\$151.98	\$159.58	\$167.56	\$175.94	\$184.73	\$193.97
<b>TOTAL MIDDLE ESTIMATE</b>	<b>\$1,275,872</b>	<b>\$3,732,271</b>	<b>\$4,629,336</b>	<b>\$5,725,455</b>	<b>\$7,067,262</b>	<b>\$8,686,167</b>
<b>High Estimate</b>						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Patient days/\$LwA	4.92	11.34	11.34	11.34	11.34	11.34
Patient days (units)	8,395	33,223	39,748	47,236	55,948	65,959
Unit cost	\$151.98	\$159.58	\$167.56	\$175.94	\$184.73	\$193.97
<b>TOTAL HIGH ESTIMATE</b>	<b>\$1,275,872</b>	<b>\$5,301,706</b>	<b>\$6,660,013</b>	<b>\$8,310,437</b>	<b>\$10,335,439</b>	<b>\$12,793,954</b>

BBPLAN.WK1

A271..I315



## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
HOME HEALTH AND IN-HOME HOSPICE CARE						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Patient days/#LWA	17.12	17.12	17.12	17.12	17.12	17.12
Patient days (units)	29,200	32,247	34,472	35,533	38,117	39,872
Unit cost	\$100.93	\$105.98	\$111.28	\$116.84	\$122.68	\$128.82
TOTAL LOW ESTIMATE	\$2,947,235	\$3,417,480	\$3,835,958	\$4,151,748	\$4,676,416	\$5,136,236
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Patient days/#LWA	17.12	17.12	17.12	17.12	17.12	17.12
Patient days (units)	29,200	35,310	41,712	49,132	57,758	67,608
Unit cost	\$100.93	\$105.98	\$111.28	\$116.84	\$122.68	\$128.82
TOTAL MIDDLE ESTIMATE	\$2,947,235	\$3,742,176	\$4,641,623	\$5,740,652	\$7,086,020	\$8,709,221
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Patient days/#LWA	17.12	17.12	17.12	17.12	17.12	17.12
Patient days (units)	29,200	50,159	60,009	71,314	84,468	99,581
Unit cost	\$100.93	\$105.98	\$111.28	\$116.84	\$122.68	\$128.82
TOTAL HIGH ESTIMATE	\$2,947,235	\$5,315,777	\$6,677,690	\$8,332,494	\$10,362,871	\$12,827,911

88PLAN.WK1  
A316..I360

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
<b>EMERGENCY HOUSING</b>						
<b>Low Estimate</b>						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Resident days/#LWA	1.48	1.34	1.25	1.21	1.13	1.08
Resident days (units)	2,518	2,518	2,518	2,518	2,518	2,518
Unit cost	\$52.49	\$55.11	\$57.87	\$60.76	\$63.80	\$66.99
TOTAL LOW ESTIMATE	\$132,160	\$138,768	\$145,706	\$152,992	\$160,641	\$168,673
<b>Middle Estimate</b>						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Resident days/#LWA	1.48	1.22	1.03	0.88	0.75	0.64
Resident days (units)	2,518	2,518	2,518	2,518	2,518	2,518
Unit cost	\$52.49	\$55.11	\$57.87	\$60.76	\$63.80	\$66.99
TOTAL MIDDLE ESTIMATE	\$132,160	\$138,768	\$145,706	\$152,992	\$160,641	\$168,673
<b>High Estimate</b>						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Resident days/#LWA	1.48	0.86	0.72	0.60	0.51	0.43
Resident days (units)	2,518	2,518	2,518	2,518	2,518	2,518
Unit cost	\$52.49	\$55.11	\$57.87	\$60.76	\$63.80	\$66.99
TOTAL HIGH ESTIMATE	\$132,160	\$138,768	\$145,706	\$152,992	\$160,641	\$168,673

88PLAN.WK1

A361..1405

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
LONG TERM INDEPENDENT HOUSING (SHANTI)						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Resident days/#LwA	9.96	9.02	8.44	8.19	7.63	7.30
Resident days (units)	17,000	17,000	17,000	17,000	17,000	17,000
Unit cost	\$36.57	\$38.40	\$40.32	\$42.33	\$44.45	\$46.67
TOTAL LOW ESTIMATE	\$621,644	\$652,726	\$685,363	\$719,631	\$755,612	\$793,393
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Resident days/#LwA	9.96	8.24	6.98	5.92	5.04	4.30
Resident days (units)	17,000	17,000	17,000	17,000	17,000	17,000
Unit cost	\$36.57	\$38.40	\$40.32	\$42.33	\$44.45	\$46.67
TOTAL MIDDLE ESTIMATE	\$621,644	\$652,726	\$685,363	\$719,631	\$755,612	\$793,393
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Resident days/#LwA	9.96	5.80	4.85	4.08	3.44	2.92
Resident days (units)	17,000	17,000	17,000	17,000	17,000	17,000
Unit cost	\$36.57	\$38.40	\$40.32	\$42.33	\$44.45	\$46.67
TOTAL HIGH ESTIMATE	\$621,644	\$652,726	\$685,363	\$719,631	\$755,612	\$793,393

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A406..I450



## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
OTHER HOUSING SUPPORT						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Resident days/#LwA	8.56	27.94	28.61	28.90	29.53	29.92
Resident days (units)	14,600	52,634	57,613	59,987	65,770	69,695
Unit cost	\$21.05	\$22.11	\$23.21	\$24.37	\$25.59	\$26.87
TOTAL LOW ESTIMATE	\$307,398	\$1,163,598	\$1,337,346	\$1,462,086	\$1,683,186	\$1,872,829
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Resident days/#LwA	8.56	28.84	30.29	31.50	32.51	33.36
Resident days (units)	14,600	59,489	73,812	90,414	109,716	131,756
Unit cost	\$21.05	\$22.11	\$23.21	\$24.37	\$25.59	\$26.87
TOTAL MIDDLE ESTIMATE	\$307,398	\$1,315,149	\$1,713,386	\$2,203,698	\$2,807,856	\$3,540,501
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Resident days/#LwA	8.56	31.64	32.73	33.61	34.34	34.94
Resident days (units)	14,600	92,712	114,752	140,047	169,479	203,295
Unit cost	\$21.05	\$22.11	\$23.21	\$24.37	\$25.59	\$26.87
TOTAL HIGH ESTIMATE	\$307,398	\$2,049,618	\$2,663,709	\$3,413,427	\$4,337,308	\$5,462,877

88PLAN.WK1

A451..I495

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
ASSISTANCE WITH DAILY LIVING (Shanti Project/Practical Support)						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Contact hours/#LWA	36.93	36.93	36.93	36.93	36.93	36.93
Contact hours (units)	63,000	69,573	74,374	76,664	82,240	86,025
Unit cost	\$6.17	\$6.48	\$6.81	\$7.15	\$7.50	\$7.88
TOTAL LOW ESTIMATE	\$388,926	\$450,981	\$506,205	\$547,877	\$617,114	\$677,793
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Contact hours/#LWA	36.93	36.93	36.93	36.93	36.93	36.93
Contact hours (units)	63,000	76,183	89,995	106,003	124,615	145,868
Unit cost	\$6.17	\$6.48	\$6.81	\$7.15	\$7.50	\$7.88
TOTAL MIDDLE ESTIMATE	\$388,926	\$493,829	\$612,523	\$757,554	\$935,093	\$1,149,295
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Contact hours/#LWA	36.93	36.93	36.93	36.93	36.93	36.93
Contact hours (units)	63,000	108,219	129,471	153,863	182,242	214,850
Unit cost	\$6.17	\$6.48	\$6.81	\$7.15	\$7.50	\$7.88
TOTAL HIGH ESTIMATE	\$388,926	\$701,486	\$881,208	\$1,099,581	\$1,367,516	\$1,692,810

88PLAN.WK1

A496..1540

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
FOOD BANK						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Bags of groceries/#LWA	4.33	4.33	4.33	4.33	4.33	4.33
Bags (units)	7,388	8,159	8,722	8,990	9,644	10,088
Unit cost	\$33.82	\$35.51	\$37.28	\$39.15	\$41.11	\$43.16
TOTAL LOW ESTIMATE	\$249,849	\$289,714	\$325,190	\$351,960	\$396,439	\$435,419
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Bags of groceries/#LWA	4.33	4.33	4.33	4.33	4.33	4.33
Bags (units)	7,388	8,934	10,554	12,431	14,614	17,106
Unit cost	\$33.82	\$35.51	\$37.28	\$39.15	\$41.11	\$43.16
TOTAL MIDDLE ESTIMATE	\$249,849	\$317,239	\$393,489	\$486,658	\$600,710	\$738,316
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Bags of groceries/#LWA	4.33	4.33	4.33	4.33	4.33	4.33
Bags (units)	7,388	12,691	15,183	18,043	21,372	25,195
Unit cost	\$33.82	\$35.51	\$37.28	\$39.15	\$41.11	\$43.16
TOTAL HIGH ESTIMATE	\$249,849	\$450,640	\$566,095	\$706,379	\$878,502	\$1,087,474

BBPLAN.WK1

A541..1585



## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
<b>MEALS DELIVERY</b>						
<b>Low Estimate</b>						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Deliveries/#LwA	74.44	74.44	74.44	74.44	74.44	74.44
Deliveries (units)	127,000	140,251	149,928	154,544	165,785	173,415
Unit cost	\$2.39	\$2.51	\$2.63	\$2.77	\$2.91	\$3.05
<b>TOTAL LOW ESTIMATE</b>	<b>\$303,530</b>	<b>\$351,960</b>	<b>\$395,058</b>	<b>\$427,580</b>	<b>\$481,615</b>	<b>\$528,971</b>
<b>Middle Estimate</b>						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Deliveries/#LwA	74.44	74.44	74.44	74.44	74.44	74.44
Deliveries (units)	127,000	153,576	181,418	213,689	251,208	294,050
Unit cost	\$2.39	\$2.51	\$2.63	\$2.77	\$2.91	\$3.05
<b>TOTAL MIDDLE ESTIMATE</b>	<b>\$303,530</b>	<b>\$385,399</b>	<b>\$478,032</b>	<b>\$591,219</b>	<b>\$729,775</b>	<b>\$896,946</b>
<b>High Estimate</b>						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Deliveries/#LwA	74.44	74.44	74.44	74.44	74.44	74.44
Deliveries (units)	127,000	218,156	260,998	310,167	367,377	433,110
Unit cost	\$2.39	\$2.51	\$2.63	\$2.77	\$2.91	\$3.05
<b>TOTAL HIGH ESTIMATE</b>	<b>\$303,530</b>	<b>\$547,462</b>	<b>\$687,722</b>	<b>\$858,147</b>	<b>\$1,067,252</b>	<b>\$1,321,122</b>

88PLAN.WK1

A586..1630

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
SOCIAL SERVICE ADVOCACY (SF AIDS FOUNDATION)						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Clients/#LWA	0.94	0.94	0.94	0.94	0.94	0.94
Clients (units)	1,600	1,767	1,889	1,947	2,089	2,185
Unit cost	\$250.50	\$263.02	\$276.17	\$289.98	\$304.48	\$319.71
TOTAL LOW ESTIMATE	\$400,798	\$464,747	\$521,656	\$564,601	\$635,951	\$698,483
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Clients/#LWA	0.94	0.94	0.94	0.94	0.94	0.94
Clients (units)	1,600	1,935	2,286	2,692	3,165	3,705
Unit cost	\$250.50	\$263.02	\$276.17	\$289.98	\$304.48	\$319.71
TOTAL MIDDLE ESTIMATE	\$400,798	\$508,903	\$631,220	\$780,678	\$963,636	\$1,184,377
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Clients/#LWA	0.94	0.94	0.94	0.94	0.94	0.94
Clients (units)	1,600	2,748	3,288	3,908	4,628	5,457
Unit cost	\$250.50	\$263.02	\$276.17	\$289.98	\$304.48	\$319.71
TOTAL HIGH ESTIMATE	\$400,798	\$722,899	\$908,107	\$1,133,146	\$1,409,259	\$1,744,483

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A631..1675

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
IN HOME ASSESSMENTS AND STATE MANDATED CASE MANAGEMENT						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Clients/#LWA	0.08	0.15	0.15	0.15	0.15	0.15
Clients (units)	130	280	299	309	331	346
Unit cost	\$1,580.51	\$1,931.53	\$2,028.10	\$2,129.51	\$2,235.98	\$2,347.78
TOTAL LOW ESTIMATE	\$205,466	\$540,827	\$607,052	\$657,027	\$740,058	\$812,826
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Clients/#LWA	0.08	0.15	0.15	0.15	0.15	0.15
Clients (units)	130	307	362	427	502	587
Unit cost	\$1,580.51	\$1,931.53	\$2,028.10	\$2,129.51	\$2,235.98	\$2,347.78
TOTAL MIDDLE ESTIMATE	\$205,466	\$592,211	\$734,552	\$908,476	\$1,121,385	\$1,378,262
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Clients/#LWA	0.08	0.15	0.15	0.15	0.15	0.15
Clients (units)	130	436	521	619	733	865
Unit cost	\$1,580.51	\$1,931.53	\$2,028.10	\$2,129.51	\$2,235.98	\$2,347.78
TOTAL HIGH ESTIMATE	\$205,466	\$841,239	\$1,056,766	\$1,318,644	\$1,639,957	\$2,030,058

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A676..1720



## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
DAY CARE						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Client day/\$LwA	0.00	19.26	19.26	19.26	19.26	19.26
Client days (units)	0	36,277	38,781	39,975	42,882	44,856
Unit cost	n/a	\$69.54	\$73.02	\$76.67	\$80.50	\$84.53
TOTAL LOW ESTIMATE	\$0	\$2,522,737	\$2,831,651	\$3,064,764	\$3,452,066	\$3,791,499
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Clients/\$LwA	0.00	19.26	19.26	19.26	19.26	19.26
Clients (units)	0	39,724	46,926	55,273	64,978	76,059
Unit cost	n/a	\$69.54	\$73.02	\$76.67	\$80.50	\$84.53
TOTAL MIDDLE ESTIMATE	\$0	\$2,762,424	\$3,426,383	\$4,237,670	\$5,230,803	\$6,429,028
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Clients/\$LwA	0.00	19.26	19.26	19.26	19.26	19.26
Clients (units)	0	56,428	67,510	80,228	95,026	112,029
Unit cost	n/a	\$69.54	\$73.02	\$76.67	\$80.50	\$84.53
TOTAL HIGH ESTIMATE	\$0	\$3,924,034	\$4,929,379	\$6,150,933	\$7,649,730	\$9,469,389

B8PLAN.WK1

A721..1765

GROUP (2):

OTHER SERVICES VARYING WITH NUMBERS OF LIVING PERSONS WITH AIDS

NOTES:      \*Projections assume that the reference cost (whether unit  
cost or program budget) will increase by 5% per year.

             \*Other operative assumptions are discussed earlier in  
this chapter.

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
OUTPATIENT SERVICES AT OTHER DPH-SUPPORTED CLINICS						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Est. #LwA/87-88 #LwA	1.00	1.10	1.18	1.22	1.31	1.37
Reference budget	\$1,289,615	\$1,354,096	\$1,421,801	\$1,492,891	\$1,567,535	\$1,645,912
TOTAL LOW ESTIMATE	\$1,289,615	\$1,495,379	\$1,678,491	\$1,816,671	\$2,046,249	\$2,247,451
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Est. #LwA/87-88 #LwA	1.00	1.21	1.43	1.68	1.98	2.32
Reference budget	\$1,289,615	\$1,354,096	\$1,421,801	\$1,492,891	\$1,567,535	\$1,645,912
TOTAL MIDDLE ESTIMATE	\$1,289,615	\$1,637,456	\$2,031,025	\$2,511,924	\$3,100,614	\$3,810,874
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Est. #LwA/87-88 #LwA	1.00	1.72	2.06	2.44	2.89	3.41
Reference budget	\$1,289,615	\$1,354,096	\$1,421,801	\$1,492,891	\$1,567,535	\$1,645,912
TOTAL HIGH ESTIMATE	\$1,289,615	\$2,326,013	\$2,921,942	\$3,646,031	\$4,534,458	\$5,613,080

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## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
A2T SUBSIDIES						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Est. #LwA/87-88 #LwA	1.00	1.10	1.18	1.22	1.31	1.37
Reference budget	\$2,735,553	\$2,872,331	\$3,015,947	\$3,166,745	\$3,325,082	\$3,491,336
TOTAL LOW ESTIMATE	\$2,735,553	\$3,172,023	\$3,560,444	\$3,853,553	\$4,340,538	\$4,767,331
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Est. #LwA/87-88 #LwA	1.00	1.21	1.43	1.68	1.98	2.32
Reference budget	\$2,735,553	\$2,872,331	\$3,015,947	\$3,166,745	\$3,325,082	\$3,491,336
TOTAL MIDDLE ESTIMATE	\$2,735,553	\$3,473,399	\$4,308,243	\$5,328,335	\$6,577,074	\$8,083,691
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Est. #LwA/87-88 #LwA	1.00	1.72	2.06	2.44	2.89	3.41
Reference budget	\$2,735,553	\$2,872,331	\$3,015,947	\$3,166,745	\$3,325,082	\$3,491,336
TOTAL HIGH ESTIMATE	\$2,735,553	\$4,933,977	\$6,198,072	\$7,734,022	\$9,618,569	\$11,906,560

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## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
LEGAL EDUCATION AND DISCRIMINATION COMPLAINTS						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Est. #LwA/87-88 #LwA	1.00	1.10	1.18	1.22	1.31	1.37
Reference budget	\$208,762	\$219,200	\$230,160	\$241,668	\$253,752	\$266,439
TOTAL LOW ESTIMATE	\$208,762	\$242,071	\$271,713	\$294,081	\$331,245	\$363,816
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Est. #LwA/87-88 #LwA	1.00	1.21	1.43	1.68	1.98	2.32
Reference budget	\$208,762	\$219,200	\$230,160	\$241,668	\$253,752	\$266,439
TOTAL MIDDLE ESTIMATE	\$208,762	\$265,070	\$328,781	\$406,629	\$501,925	\$616,902
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Est. #LwA/87-88 #LwA	1.00	1.72	2.06	2.44	2.89	3.41
Reference budget	\$208,762	\$219,200	\$230,160	\$241,668	\$253,752	\$266,439
TOTAL HIGH ESTIMATE	\$208,762	\$376,533	\$473,002	\$590,217	\$734,035	\$908,642

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## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
COORDINATION OF CHRONIC CARE, HOUSING, AND RELATED SUPPORT SERVICES						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Est. #LwA/87-88 #LwA	1.00	1.10	1.18	1.22	1.31	1.37
Reference budget	\$397,429	\$417,300	\$438,165	\$460,074	\$483,077	\$507,231
TOTAL LOW ESTIMATE	\$397,429	\$460,841	\$517,272	\$559,855	\$630,606	\$692,612
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Est. #LwA/87-88 #LwA	1.00	1.21	1.43	1.68	1.98	2.32
Reference budget	\$397,429	\$417,300	\$438,165	\$460,074	\$483,077	\$507,231
TOTAL MIDDLE ESTIMATE	\$397,429	\$504,625	\$625,914	\$774,116	\$955,536	\$1,174,422
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Est. #LwA/87-88 #LwA	1.00	1.72	2.06	2.44	2.89	3.41
Reference budget	\$397,429	\$417,300	\$438,165	\$460,074	\$483,077	\$507,231
TOTAL HIGH ESTIMATE	\$397,429	\$716,822	\$900,474	\$1,123,621	\$1,397,413	\$1,729,819

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A901..1945



## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
MENTAL HEALTH SERVICES REFLECTING NUMBER LIVING WITH AIDS						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Est. #LwA/87-88 #LwA	1.00	1.10	1.18	1.22	1.31	1.37
Reference budget	\$3,147,631	\$3,305,013	\$3,470,263	\$3,643,776	\$3,825,965	\$4,017,263
TOTAL LOW ESTIMATE	\$3,147,631	\$3,649,850	\$4,096,782	\$4,434,044	\$4,994,387	\$5,485,472
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Est. #LwA/87-88 #LwA	1.00	1.21	1.43	1.68	1.98	2.32
Reference budget	\$3,147,631	\$3,305,013	\$3,470,263	\$3,643,776	\$3,825,965	\$4,017,263
TOTAL MIDDLE ESTIMATE	\$3,147,631	\$3,996,624	\$4,957,228	\$6,130,985	\$7,567,831	\$9,301,401
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Est. #LwA/87-88 #LwA	1.00	1.72	2.06	2.44	2.89	3.41
Reference budget	\$3,147,631	\$3,305,013	\$3,470,263	\$3,643,776	\$3,825,965	\$4,017,263
TOTAL HIGH ESTIMATE	\$3,147,631	\$5,677,221	\$7,131,737	\$8,899,059	\$11,067,490	\$13,700,140

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## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
SUBSTANCE ABUSE TREATMENT SERVICES REFLECTING NUMBER LIVING WITH AIDS*						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Est. #LwA/87-88 #LwA	1.00	1.10	1.18	1.22	1.31	1.37
Reference budget	\$557,910	\$585,806	\$615,096	\$645,851	\$678,143	\$712,050
TOTAL LOW ESTIMATE	\$557,910	\$646,927	\$726,145	\$785,924	\$885,243	\$972,287
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Est. #LwA/87-88 #LwA	1.00	1.21	1.43	1.68	1.98	2.32
Reference budget	\$557,910	\$585,806	\$615,096	\$645,851	\$678,143	\$712,050
TOTAL MIDDLE ESTIMATE	\$557,910	\$708,392	\$878,657	\$1,086,702	\$1,341,380	\$1,648,651
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Est. #LwA/87-88 #LwA	1.00	1.72	2.06	2.44	2.89	3.41
Reference budget	\$557,910	\$585,806	\$615,096	\$645,851	\$678,143	\$712,050
TOTAL HIGH ESTIMATE	\$557,910	\$1,006,274	\$1,264,083	\$1,577,337	\$1,961,686	\$2,428,317

\*Baker Places, UCSF AIDS Health Project, and SF6H/PACE

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A991..11035

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
AIDS RELATED ADMINISTRATIVE SUPPORT AND COORDINATION (DPH CENTRAL OFFICE)						
Low Estimate						
# Living with AIDS	1,706	1,884	2,014	2,076	2,227	2,330
Est. #LwA/87-88 #LwA	1.00	1.10	1.18	1.22	1.31	1.37
Reference budget	\$824,809	\$866,049	\$909,352	\$954,820	\$1,002,560	\$1,052,689
TOTAL LOW ESTIMATE	\$824,809	\$956,411	\$1,073,526	\$1,161,902	\$1,308,735	\$1,437,420
Middle Estimate						
# Living with AIDS	1,706	2,063	2,437	2,871	3,375	3,950
Est. #LwA/87-88 #LwA	1.00	1.21	1.43	1.68	1.98	2.32
Reference budget	\$824,809	\$866,049	\$909,352	\$954,820	\$1,002,560	\$1,052,689
TOTAL MIDDLE ESTIMATE	\$824,809	\$1,047,280	\$1,298,998	\$1,606,571	\$1,983,083	\$2,437,350
High Estimate						
# Living with AIDS	1,706	2,931	3,506	4,167	4,935	5,818
Est. #LwA/87-88 #LwA	1.00	1.72	2.06	2.44	2.89	3.41
Reference budget	\$824,809	\$866,049	\$909,352	\$954,820	\$1,002,560	\$1,052,689
TOTAL HIGH ESTIMATE	\$824,809	\$1,487,666	\$1,868,809	\$2,331,920	\$2,900,138	\$3,590,001

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A1036..11080



GROUP (3):

WHOSE COSTS ARE NOT EXPECTED TO VARY WITH THE NUMBER LIVING WITH AIDS

NOTES:      \*Projections assume that the reference cost (whether unit cost or program budget) will increase by 5% per year.

             \*Other operative assumptions are discussed earlier in this chapter.

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
EPIDEMIOLOGY AND RELATED RESEARCH (OTHER THAN AIDS SURVEILLANCE)						
Reference budget	\$4,570,366	\$4,570,366	\$4,798,884	\$5,038,829	\$5,290,770	\$5,555,308
Factor of increase	1.00	1.05	1.05	1.05	1.05	1.05
TOTAL ESTIMATE	\$4,570,366	\$4,798,884	\$5,038,829	\$5,290,770	\$5,555,308	\$5,833,074

(SAME FOR LOW, MIDDLE AND HIGH PROJECTIONS)

	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
PUBLIC EDUCATION						
Reference budget	\$4,806,403	\$4,806,403	\$5,046,723	\$5,299,059	\$5,564,012	\$5,842,213
Factor of increase	1.00	1.05	1.05	1.05	1.05	1.05
TOTAL ESTIMATE	\$4,806,403	\$5,046,723	\$5,299,059	\$5,564,012	\$5,842,213	\$6,134,324

(SAME FOR LOW, MIDDLE AND HIGH PROJECTIONS)

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## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
Reference budget	\$945,176	\$945,176	\$992,435	\$1,042,057	\$1,094,159	\$1,148,867
Factor of increase	1.00	1.05	1.05	1.05	1.05	1.05
TOTAL ESTIMATE	\$945,176	\$992,435	\$1,042,057	\$1,094,159	\$1,148,867	\$1,206,311

(SAME FOR LOW, MIDDLE AND HIGH PROJECTIONS)

## NEEDS ASSESSMENTS\*

	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
Reference budget	\$250,000	\$250,000	\$262,500	\$275,625	\$289,406	\$303,877
Factor of increase	1.00	1.05	1.05	1.05	1.05	1.05
TOTAL ESTIMATE	\$250,000	\$262,500	\$275,625	\$289,406	\$303,877	\$319,070

(SAME FOR LOW, MIDDLE AND HIGH PROJECTIONS)

\*Associated in other budget documents with chronic care, housing and related support services

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A1126..11170



## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

	(C)	(D)	(E)	(F)	(G)	(H)	(I)
		1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
SUBSTANCE ABUSE PREVENTION AND TREATMENT NOT REFLECTING NUMBER LIVING WITH AIDS							
Reference budget		\$1,336,001	\$1,336,001	\$1,402,801	\$1,472,941	\$1,546,588	\$1,623,918
Factor of increase		1.00	1.05	1.05	1.05	1.05	1.05
TOTAL ESTIMATE		\$1,336,001	\$1,402,801	\$1,472,941	\$1,546,588	\$1,623,918	\$1,705,113

(SAME FOR LOW, MIDDLE AND HIGH PROJECTIONS)

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A1171..11215

GROUP (4): FOR WHICH DEMAND IS DETERMINED BY SOME OTHER VARIABLE

NOTES:      \*Projections assume that the reference cost (whether unit cost or program budget) will increase by 5% per year.

             \*Other operative assumptions are discussed earlier in this chapter.

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE DEMANDS AND COSTS, 1988-1993

(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
AIDS SURVEILLANCE						
Low Estimate						
# Diagnosed with AIDS	1,355	1,384	1,411	1,439	1,468	1,495
Est. # cases/87-88 cases	1.00	1.02	1.04	1.06	1.08	1.10
Reference budget*	\$304,466	\$495,097	\$519,852	\$545,844	\$573,137	\$601,793
TOTAL LOW ESTIMATE	\$304,466	\$505,693	\$541,337	\$579,683	\$620,933	\$663,971
Middle Estimate						
# Diagnosed with AIDS	1,355	1,543	1,693	1,870	2,072	2,292
Est. # cases/87-88 cases	1.00	1.14	1.25	1.38	1.53	1.69
Reference budget*	\$304,466	\$495,097	\$519,852	\$545,844	\$573,137	\$601,793
TOTAL MIDDLE ESTIMATE	304,466	563,789	649,335	753,306	876,413	1,017,719
High Estimate						
# Diagnosed with AIDS	1,355	1,702	1,974	2,301	2,676	3,088
Est. # cases/87-88 cases	1.00	1.26	1.46	1.70	1.97	2.28
Reference budget*	\$304,466	\$495,097	\$519,852	\$545,844	\$573,137	\$601,793
TOTAL HIGH ESTIMATE	\$304,466	\$621,886	\$757,334	\$926,928	\$1,131,892	\$1,371,467

NOTE: The 1987-88 budget for these services was for part of the year only. The 1988-89 budget reflects an annualized base as well as a 5% annual COLA.

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A1216..I1260



SUMMARIES OF FUTURE SERVICE COST ESTIMATES

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE COSTS, 1988-1993

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LOW ESTIMATE  
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(C)	(D)	(E)	(F)	(G)	(H)	(I)
	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
SURVEILLANCE, EPIDEMIOLOGY AND RELATED RESEARCH	\$4,874,832	\$5,304,577	\$5,580,165	\$5,870,453	\$6,176,242	\$6,497,045
PUBLIC EDUCATION	\$4,806,403	\$5,046,723	\$5,299,059	\$5,564,012	\$5,842,213	\$6,134,324
PROVIDER EDUCATION AND STAFF SUPPORT	\$945,176	\$992,435	\$1,042,057	\$1,094,159	\$1,148,867	\$1,206,311
PRIMARY AND SPECIALIZED OUTPATIENT CARE	\$21,637,677	\$25,090,049	\$28,162,348	\$30,480,742	\$34,332,639	\$37,708,432
HOSPITAL INPATIENT CARE	\$42,456,118	\$49,392,533	\$55,553,494	\$60,179,675	\$67,915,767	\$74,680,795
CHRONIC CARE, HOUSING AND RELATED SUPPORT SERVICES	\$8,677,968	\$15,922,549	\$17,827,199	\$19,273,673	\$21,656,926	\$23,751,569
AIDS-RELATED MENTAL HEALTH SERVICES	\$3,147,631	\$3,649,850	\$4,096,782	\$4,434,044	\$4,994,387	\$5,485,472
AIDS-SPECIFIC SUBSTANCE ABUSE SERVICES	\$1,893,911	\$2,049,728	\$2,199,086	\$2,332,512	\$2,509,161	\$2,677,400
ADMINISTRATIVE SUPPORT AND COORDINATION	\$824,809	\$956,411	\$1,073,526	\$1,161,902	\$1,308,735	\$1,437,420
TOTAL LOW ESTIMATE	\$89,264,525	\$108,404,855	\$120,833,715	\$130,391,172	\$145,884,937	\$159,578,766

Note: Based on current service utilization patterns and currently anticipated adjustments in future years.

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A1621..I1665

## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE COSTS, 1988-1993

## MIDDLE ESTIMATE

(C)	(D) 1987-88	(E) 1988-89	(F) 1989-90	(G) 1990-91	(H) 1991-92	(I) 1992-93
SURVEILLANCE, EPIDEMIOLOGY AND RELATED RESEARCH	\$4,874,832	\$5,362,674	\$5,688,164	\$6,044,076	\$6,431,721	\$6,850,793
PUBLIC EDUCATION	\$4,806,403	\$5,046,723	\$5,299,059	\$5,564,012	\$5,842,213	\$6,134,324
PROVIDER EDUCATION AND STAFF SUPPORT	\$945,176	\$992,435	\$1,042,057	\$1,094,159	\$1,148,867	\$1,206,311
PRIMARY AND SPECIALIZED OUTPATIENT CARE	\$21,637,677	\$27,473,870	\$34,077,280	\$42,145,939	\$52,023,121	\$63,940,033
HOSPITAL INPATIENT CARE	\$42,456,118	\$54,233,184	\$67,564,528	\$83,867,394	\$103,838,662	\$127,947,639
CHRONIC CARE, HOUSING AND RELATED SUPPORT SERVICES	\$8,677,968	\$17,376,216	\$21,434,161	\$26,387,190	\$32,444,716	\$39,747,815
AIDS-RELATED MENTAL HEALTH SERVICES	\$3,147,631	\$3,996,624	\$4,957,228	\$6,130,985	\$7,567,831	\$9,301,401
AIDS-SPECIFIC SUBSTANCE ABUSE SERVICES	\$1,893,911	\$2,111,193	\$2,351,598	\$2,633,290	\$2,965,297	\$3,353,764
ADMINISTRATIVE SUPPORT AND COORDINATION	\$824,809	\$1,047,280	\$1,298,998	\$1,606,571	\$1,983,083	\$2,437,350
TOTAL MIDDLE ESTIMATE	\$89,264,525	\$117,640,198	\$143,713,072	\$175,473,615	\$214,245,512	\$260,919,430

Note: Based on current service utilization patterns and currently anticipated adjustments in future years.

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A1666..11710



## AIDS IN SAN FRANCISCO: ESTIMATES OF SERVICE COSTS, 1988-1993

## HIGH ESTIMATE

(C)	(D) 1987-88	(E) 1988-89	(F) 1989-90	(G) 1990-91	(H) 1991-92	(I) 1992-93
SURVEILLANCE, EPIDEMIOLOGY AND RELATED RESEARCH	\$4,874,832	\$5,420,770	\$5,796,163	\$6,217,698	\$6,687,200	\$7,204,541
PUBLIC EDUCATION	\$4,806,403	\$5,046,723	\$5,299,059	\$5,564,012	\$5,842,213	\$6,134,324
PROVIDER EDUCATION AND STAFF SUPPORT	\$945,176	\$992,435	\$1,042,057	\$1,094,159	\$1,148,867	\$1,206,311
PRIMARY AND SPECIALIZED OUTPATIENT CARE	\$21,637,677	\$39,026,745	\$49,025,418	\$61,174,379	\$76,080,635	\$94,178,002
HOSPITAL INPATIENT CARE	\$42,456,118	\$77,692,763	\$97,918,655	\$122,507,146	\$152,690,669	\$189,349,963
CHRONIC CARE, HOUSING AND RELATED SUPPORT SERVICES	\$8,677,968	\$24,421,222	\$30,549,627	\$37,990,862	\$47,115,169	\$58,187,179
AIDS-RELATED MENTAL HEALTH SERVICES	\$3,147,631	\$5,677,221	\$7,131,737	\$8,899,059	\$11,067,490	\$13,700,140
AIDS-SPECIFIC SUBSTANCE ABUSE SERVICES	\$1,893,911	\$2,409,075	\$2,737,024	\$3,123,925	\$3,585,603	\$4,133,430
ADMINISTRATIVE SUPPORT AND COORDINATION	\$824,809	\$1,487,666	\$1,868,809	\$2,331,920	\$2,900,138	\$3,590,001
TOTAL HIGH ESTIMATE	\$89,264,525	\$162,174,619	\$201,368,547	\$248,903,161	\$307,117,985	\$377,683,891

Note: Based on current service utilization patterns and currently anticipated adjustments in future years.

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A1711..11755

APPENDIX A.

RECAPITULATION OF POLICY STATEMENTS

**A. POLICY REAFFIRMATION REGARDING SURVEILLANCE, EPIDEMIOLOGY, AND RELATED RESEARCH**

1. DPH reaffirms its commitment to conduct surveillance of HIV infection and to conduct research in order to develop and evaluate policies designed to prevent the spread of HIV infection.
2. DPH reaffirms its commitment to maintain a structured and accurate surveillance system, including a routine evaluation of the effectiveness of the various components of this program.
3. DPH reaffirms its commitment to careful behavioral and serologic assessments of populations targeted for education and prevention support programs to maximize the effectiveness of these programs.
4. DPH reaffirms its commitment to evaluate educational, behavioral, and therapeutic research efforts on an ongoing basis and to disseminate the results in order that the most effective prevention and treatment approaches are known to public health and clinical practitioners in San Francisco.
5. DPH reaffirms its commitment to evaluate substance abuse and other treatment interventions as well as educational strategies in order to determine the most cost efficient systems of care.
6. DPH reaffirms its commitment to ensuring that the confidentiality of client/participant records associated with these surveillance and research activities will be scrupulously protected.

**B. POLICY REAFFIRMATION REGARDING PUBLIC EDUCATION**

1. The focal point of coordination of AIDS education (both public education and prevention support) in San Francisco should be the San Francisco Department of Public Health. DPH will seek the cooperation of the media, schools, physicians, dentists, other health professionals, community organizations, and individuals in developing and implementing effective education/information programs in combination with programs designed to support behaviors that do not put a person at risk of HIV infection.
2. The design and content of AIDS education and intervention efforts should be based on epidemiologic, behavioral, and social science research as well as careful assessments of targeted audiences' understanding of AIDS and its transmission, and of the obstacles which prevent adoption or maintenance of behaviors that do not put the person at risk of HIV infection.
3. DPH recognizes the importance of the evaluation of educational interventions and will support constructive ongoing evaluation when it can be regarded as cost-effective.
4. Educational materials should utilize language and visuals which the audience(s) targeted are most likely to understand and to which they will respond. Judgments about the propriety of materials produced and distributed with public funds should be made by local public health authorities and local review panels and should be based on careful assessments of the needs of local audiences.
5. The organizational bases from which AIDS education efforts in San Francisco are launched should be diversified. There should be a wide range of community settings and community-based organizations whose goal is to educate the general and at-risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with groups not yet well addressed by established programs (i.e. programs targeted to hard-to-reach gay men, substance abusers, racial and ethnic minority groups, out-of-school youth, street youth, and heterosexuals with multiple or at-risk partners).
6. DPH will encourage both traditional and nontraditional educational interventions in its commitment to the prevention of HIV transmission and AIDS.
7. Anonymous antibody testing should be available to anyone 14 years of age or older in the community who wishes to know his/her antibody status and is willing to participate in a pre- and post-test education and counseling program.



8. Confidential antibody testing should be promoted as a health education tool only if and when there is substantial community sentiment that procedures have been developed which adequately protect individuals participating in the program and the records of their test results. With increasing numbers of private test sites which use varying procedures for testing and for education/counseling, closer scrutiny must be made of the quality of these services.

C. POLICY REAFFIRMATION REGARDING THE CONCERNS OF GAY AND BISEXUAL MEN

1. DPH should maintain its commitment to involving leaders from the gay community in program planning and policy setting. Although gay and bisexual men have been active as advocates and service providers in combating the AIDS epidemic from its outset, their influence and contributions to meeting the needs of the epidemic should not be taken for granted.
2. DPH should ensure the development of prevention education programs and intervention strategies in San Francisco which will meet the unique needs of gay and bisexual men in a timely fashion.
3. The design and content of AIDS education and intervention efforts among gay and bisexual groups should be shaped by information from epidemiologic research as well as careful assessments of (a) what targeted audiences already understand about AIDS and its transmission and (b) what stands in the way of their adopting or maintaining new behaviors.
4. Particular attention needs to be paid to AIDS education and prevention programs which will communicate effectively with the gay community. Individuals with cultural ties to targeted communities should be involved in the design of programs and research.
5. AIDS provider education must directly address attitudes that may distort the way in which information about AIDS is received by professionals who participate in training. Of particular concern where AIDS is an issue are attitudes about homosexual lifestyles.
6. DPH should ensure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture, and language should be evident in all service settings.
7. DPH should make every effort to ensure that staff in contract services and DPH settings in which services are planned or provided are culturally sensitive. In this context, one's identity as a gay person is the equivalent of one's racial or ethnic identity. Staffing patterns should reflect the populations targeted and served.
8. DPH should ensure that each AIDS service contractor includes in its annual program proposal a plan for addressing the special needs of the members of gay and bisexual groups as they relate to the services concerned.
9. DPH should ensure that gay and bisexual men participate in the Department's periodic monitoring of contract services.
10. DPH reaffirms its commitment to the enforcement of the City's AIDS antidiscrimination policy.

**D. POLICY REAFFIRMATION REGARDING CONCERNS OF RACIAL AND ETHNIC MINORITY GROUPS**

1. DPH will develop and implement, with minority community organizations, prevention education programs, intervention strategies, and treatment programs in San Francisco which will meet the unique needs of racial and ethnic minority groups at risk for AIDS.
2. The design and content of AIDS education and intervention efforts among racial and ethnic minority groups should be shaped by information from epidemiologic, behavioral, and social sciences research, the experience of community leaders and the media, and careful assessments of what targeted audiences already understand about AIDS and its transmission and of what stands in the way of their adopting or maintaining new behaviors that do not put them at risk for HIV infection.
3. The organizational bases from which AIDS education efforts in San Francisco are launched should be diversified. There should be a wide range of community settings and community-based organizations that educate the general and at-risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with people from racial and ethnic minority groups. Individuals with cultural ties to target communities should be involved in the design of programs and research.
4. AIDS provider education must directly address attitudes that may distort the way in which information about AIDS is received by professionals who participate in training. Of particular concern where AIDS is an issue are attitudes about racial and ethnic minority groups.
5. DPH should ensure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture, and language should be evident in all service settings.
6. DPH should make every effort to ensure that staff in contract services and DPH settings in which services are planned or provided are culturally sensitive and, where monolingual clients are involved, language specific. Staffing patterns should reflect the populations targeted and served.
7. DPH should ensure that each AIDS service contractor includes in its annual program proposal a plan for addressing the special needs of the members of racial and ethnic minority groups as they relate to the services concerned.



8. DPH should ensure that racial and ethnic minority groups participate in the Department's periodic monitoring of contract services.
9. DPH reaffirms its commitment to the enforcement of the City's AIDS antidiscrimination policy.

**E. POLICY REAFFIRMATION REGARDING CONCERNS OF WOMEN**

1. DPH, in cooperation with women's groups, will ensure the development and implementation, in a timely fashion, of prevention education programs, intervention strategies, and treatment programs in San Francisco which will meet the unique needs of women at risk for AIDS.
2. The design and content of AIDS education and intervention efforts among women should be shaped by information from epidemiologic, behavioral, and social sciences research, and careful assessments of what targeted audiences already understand about AIDS and its transmission and of what stands in the way of their adopting or maintaining new behaviors. Women should be involved in the planning and design of programs and research that address women-specific issues.
3. There should be a wide range of community settings and community-based organizations that educate the general and at-risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with women.
4. AIDS provider education must directly address providers' attitudes that may distort the way in which they receive information delivered in trainings and the way in which they impart information to their patients/clients. Of particular concern where AIDS is an issue are attitudes about women.
5. DPH should ensure that services are provided in a manner which makes them as accessible and acceptable as possible to the patients being served. Sensitivity to gender-related differences in lifestyle, culture, and language should be incorporated in all service settings.
6. DPH should make every effort to ensure that staff in contract services and DPH settings in which services are planned or provided are sensitive to women. Staffing patterns should reflect the populations targeted and served.
7. DPH should ensure that each AIDS service contractor includes in its annual program proposal a plan for addressing the special needs of women as they relate to the services concerned.
8. DPH should ensure that women participate in the Department's periodic monitoring of contract services.
9. DPH should ensure that programs providing services and housing to women with AIDS include provisions for child care services which can help to maintain the family unit.

10. DPH should ensure that women are represented on program planning staff and staff of service agencies contracting with DPH. All staff must be trained to deal with the special needs of women. Family issues may be of particular concern for women. Sensitive issues regarding substance abuse, sexuality, family planning, pregnancy, childcare, housing, and legal matters must be addressed in an open, non-coercive manner.



**F. POLICY REAFFIRMATION REGARDING CONCERNS OF CHILDREN AND ADOLESCENTS**

1. DPH should ensure the development of prevention education programs, intervention strategies, and treatment programs in San Francisco which will meet the unique needs of children and youth at risk for AIDS.
2. The design and content of AIDS education and intervention efforts among youth should be shaped by information from epidemiologic, behavioral, and social sciences research, and careful assessments of what targeted audiences already understand about AIDS and its transmission. Where appropriate it is important to include adolescents in the planning and implementation of programs and research that address issues specific to young people.
3. There should be a wide range of community settings and community-based organizations that educate the general and at-risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with women of childbearing age, children, and adolescents.
4. AIDS provider education must directly address issues regarding perinatal transmission as well as pediatric and adolescent HIV infection. All AIDS training, in particular sessions specific to providers that specialize in services to youth, should help providers develop skills that enable them to effectively approach adolescents with AIDS prevention education.
5. DPH should ensure that services are provided in a manner which makes them as accessible and acceptable as possible to the patients being served. Sensitivity to concerns of parents with children with AIDS and to adolescents should be incorporated in all service settings.
6. DPH should make every effort to ensure that staff in contract services and DPH settings in which services are planned or provided are sensitive to the needs of children and youth. Staffing patterns should reflect the populations targeted and served.
7. DPH should ensure that each AIDS service contractor includes in its annual program proposal a plan for addressing the special needs of children and youth as they relate to the services concerned.
8. DPH reaffirms its commitment to providing ongoing medical consultation to community agencies and organizations such as the San Francisco Unified School District and Department of Social Services, who provide medical and support services for children and youth with HIV infection.

9. DPH should ensure that programs providing services and housing to women with AIDS include provisions for child care services which can help to maintain the family unit.
10. DPH reaffirms its commitment to collaborate with the San Francisco Unified School District and community agencies to provide comprehensive AIDS education and prevention programs aimed at youth both in and out of school. These programs must be culturally sensitive, acknowledge the special concerns of gay youth, and address the range of issues particular to youth and AIDS.
11. DPH acknowledges that AIDS services for children must address the child's ability to comprehend information, his/her behavior, fears, and health care and social needs. Children should be provided with appropriate information and the opportunity to participate in decisions for health care and risk reduction.
12. DPH recognizes that HIV infection in infants and children is often associated with parental HIV infection, drug abuse, poverty, homelessness, family disruption, and other significant problems. These families need special support services including advocacy, drug treatment, financial assistance, respite care, and housing. For families that are unable to care for their children, foster care and adoption should be available.
13. DPH recognizes that youth who are disenfranchised from their families (e.g. runaways and delinquents) are at particularly high risk for HIV infection due to their drug and sexual behaviors. Many adolescents fail to comprehend their risk for HIV infection and fail to access AIDS prevention education and health care. Programs that serve adolescents must utilize comprehensive, age-appropriate strategies for outreach and education, health care, psychosocial support, drug treatment, and housing.

**G. POLICY REAFFIRMATION REGARDING PROVIDER EDUCATION AND STAFF SUPPORT**

1. DPH will participate in the development of comprehensive and constructive AIDS education components in a broad spectrum of (a) professional degree training programs, (b) university-affiliated continuing education and in-service training programs, (c) training opportunities organized by professional associations and labor organizations, and (d) in-house training offered by local service providers. Experienced providers based at DPH should cooperate by making their experience available to those who are planning and implementing such training.
2. DPH should assist as much as possible in training efforts that will ultimately enhance the capacity of private-sector providers to accommodate needs generated by the AIDS epidemic.
3. DPH recognizes that, to be constructive, AIDS provider education must directly address prejudices that may distort the way in which information about AIDS is received by those who participate in training. Of particular concern where AIDS is at issue are homophobic, racist, and sexist attitudes. In addition negative or misunderstood beliefs about people with substance abuse and mental health problems and individual providers' own difficulties dealing with death and dying can adversely affect their ability to care for people with AIDS.
4. DPH recognizes that AIDS provider education programs have a special responsibility to address concerns of stress and burnout among providers. Programs must be developed in all service areas that provide care for the care-givers. These programs are essential not only to reduce staff turnover resulting from burnout but in order to assure that the care being delivered to people with AIDS is of the highest possible quality.
5. DPH expects that service providers whose professional skills are enhanced by training provided through City-sponsored programs should be expected to help defray the cost of such training.
6. DPH should ensure that there continue to be forums for the presentation and discussion of ethical dilemmas presented in the course of patient care. These "ethics committees" should meet on a regular basis and should be available to all providers with moral and ethical concerns so that issues may be resolved in a proactive manner whenever possible.
7. DPH reaffirms its commitment to the enforcement of the City's AIDS antidiscrimination policy.



**H. POLICY REAFFIRMATION REGARDING PRIMARY CARE AND SPECIALIZED OUTPATIENT CARE**

1. DPH will maintain its general focus on comprehensive outpatient care and maximize patients' potential to maintain themselves at their optimal functioning capacity at home or in residential facilities.
2. DPH will ensure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture, and language should be evident in all service settings. The special needs of women with AIDS/ARC and dependent children should be taken into account.
3. Private physicians, dentists, and other primary care providers should participate as fully as possible in the diagnosis and care of persons with clinical manifestations of HIV infection and with asymptomatic HIV infection.
4. To promote this participation, DPH/SFGH will offer opportunities to private physicians, dentists, and other primary care providers to learn about our experience and to share their experience in providing care to AIDS, ARC, and HIV-infected patients.
5. Any physician who accommodates the provisions of AB 403 can order an HIV antibody test with the informed consent of his/her patient. DPH will do the necessary laboratory work free of charge for any physician who agrees to certain guidelines regarding pre- and post-test education and counseling. The sera sent to the Lab for such testing should continue to be identified by code number alone; only the physician concerned should have a record of the patient associated with the code number.
6. DPH will design a system-wide evaluation of primary care programs, using a methodology that collects information about patient satisfaction with existing programs.
7. DPH will provide leadership in the community as an advocate for adequate resources for people with AIDS, ARC, and HIV infection that ensure culturally and linguistically appropriate services.
8. DPH, recognizing that medical care of persons with asymptomatic and mildly symptomatic HIV infection will become an increasingly important aspect of outpatient care, will provide leadership in designing, seeking funding for, and implementing clinical services for this patient group.

I. POLICY REAFFIRMATION REGARDING HOSPITAL INPATIENT CARE

1. DPH will maintain its general focus on comprehensive outpatient care and maximize patients' potential to maintain themselves at their optimal functioning level at home or in residential facilities. The demand for inpatient care is directly related to the availability and quality of outpatient care, housing, and in-home support services.
2. DPH should ensure that hospital services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, race and ethnicity, culture, and language should be evident in all service settings. The special needs of women with AIDS/ARC and dependent infants, children, and adolescents should be taken into account.
3. Physicians in private practice and the community hospitals to which they admit patients should be encouraged to participate as fully as possible in the screening and care of persons with clinical manifestations of HIV infection. DPH recognizes that the proportion of AIDS/ARC patients admitted to private community hospitals will depend on the proportion of AIDS/ARC patients whose primary care is being provided by physicians in private practice.
4. SFGH should develop a management information system which efficiently identifies and tracks the demand for various services specific to AIDS/ARC patients, their costs, and the extent to which they are covered by third party payors.
5. DPH will continue its commitment both to providing AIDS-specific training for health care personnel, and to providing routine and continuing psychosocial and emotional support for hospital staff.
6. DPH recognizes the need for an aggressive campaign to educate HIV seropositives about developing medical options and the corollary need to coordinate provision of access to these options.

J. POLICY REAFFIRMATION REGARDING CHRONIC CARE AND RELATED SUPPORT SERVICES

1. DPH will maintain its general focus on comprehensive chronic care, housing, and related support services to maximize patients' potential to maintain themselves at home or in residential facilities.
2. DPH will ensure that services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, race/ethnicity, culture, language, and gender shall be evident in all service configurations.
3. Service utilization assessments, quality assurance, and cost analyses of various service configurations will be ongoing to ensure that in the long run services provided are indeed the most appropriate from the perspective of both health care and cost.
4. DPH acknowledges the importance of support services for persons with AIDS and ARC which are now entirely funded by private donations, services such as the grocery supplement and meal delivery programs described in this chapter. DPH reaffirms its commitment to encouraging State and Federal agencies to support such programs. DPH will seek to identify categorical grant funding that would be appropriate for such services and is prepared to act as the fiscal agent for community-based providers in situations where such a fiscal agent is required.



**K. POLICY REAFFIRMATION REGARDING MENTAL HEALTH SERVICES**

1. DPH will ensure that mental health services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, race/ethnicity, culture, sexual orientation, and language should be evident in all service settings.
2. Private providers should be encouraged to participate as fully as possible in the provision of mental health services related to HIV infection.
3. DPH should maintain mental health support services to maximize the patients' potential to maintain themselves at home or in residential facilities. This includes direct care to persons with AIDS and ARC as well as to significant others whose participation in providing care at home is essential to its success.
4. Expansion of mental health services related to AIDS should parallel the development of satellite programs for primary care and specialized outpatient clinics. In other words, a satellite program designed to provide primary care to more discrete population groups (e.g. women with AIDS/ARC) or to particular neighborhoods with a high prevalence of HIV infection should be complemented with an expansion of mental health services to the same population and its support systems. Of particular concern is the availability of psychiatric assessments in instances where dementia and other forms of neurological disorder are associated with HIV infection.

**L. POLICY REAFFIRMATION REGARDING SUBSTANCE ABUSE SERVICES**

1. DPH recognizes that all current substance abuse services are in some measure AIDS prevention programs, and that all AIDS education programs in this context are substance abuse prevention programs as well. The "AIDS agenda" (substance abuse treatment as prevention, education and outreach, counseling for partners and families, etc.) will be a specific item in all program descriptions developed for FY 1988-89.
2. DPH recognizes that preventing the transmission of AIDS may require extraordinary measures, such as educating IV drug users about how to sterilize their syringes, which may create paradoxes for programs whose goals include stopping substance abuse.
3. DPH recognizes that substance abusers with AIDS/ARC present special problems for providers of health care and other support services. Support services specific to the needs of substance abusers should be developed and maintained.
4. DPH will ensure that substance abuse services are provided in a manner which makes them as accessible as possible to the patients being served. Sensitivity to differences in lifestyle, culture, and language should be evident in all service settings. Training for both AIDS and substance abuse providers will be emphasized, focusing on the special needs of substance users for AIDS providers and AIDS-specific issues for substance abuse professionals.
5. DPH will establish a priority in the development and continuation of substance abuse programs that allow families to stay together whenever possible.
6. DPH recognizes that there are currently waiting lists for methadone maintenance slots, drug-free outpatient programs, and residential treatment. It will establish a priority for these treatment programs and therefore prevention of HIV transmission to be expanded.
7. DPH recognizes that AIDS service programs are often not organized or staffed in a way that easily accommodates people with substance abuse histories. It will assure, however, that this is not used as an excuse for turning clients away if it is at all possible to care for them, and it will assure that all clients receive appropriate referrals.

# **M. POLICY REAFFIRMATION REGARDING ADMINISTRATIVE SUPPORT AND COORDINATION**

1. The Department of Public Health reaffirms its commitment to ensuring that San Francisco's response to the AIDS epidemic is equal to the task in prevention and care and is cost-effectively managed.
2. DPH also reaffirms that the financial burdens of meeting the demands of the epidemic should be distributed reasonably between the public and private sectors and, within the public sector, distributed fairly among local, state, and national resources.
3. DPH recognizes that the interests of community advocacy groups and community-based organizations must be appreciated and addressed in plans for AIDS services.
4. DPH maintains that, in situations where the local department of health has an established and credible track record in AIDS prevention and health care services, State and Federal agencies should be encouraged to support these services through block grants to the local department. Competitive application procedures in these situations create an administrative burden on all parties that does not serve the epidemic well.
5. In situations where there are opportunities for direct funding of community-based organizations, the funding agency involved should encourage close cooperation with related programs in the continuum.
6. DPH expects the California Department of Health Services to streamline its contract procedures to (a) provide much faster processing of contracts and (b) give contractors more flexibility to respond quickly and constructively to emerging needs in the area of service for which the funds are earmarked. DPH recognizes that the greater utilization of block grants mentioned above would accomplish this goal as well.
7. DPH requests that State and Federal funding be offered to local jurisdictions in a manner which encourages joint utilization of State/Federal and local dollars. State and Federal funding restrictions which arbitrarily penalize local jurisdictions which have taken the initiative to respond to needs created by the epidemic, simply because they have taken the initiative, should be withdrawn.
8. DPH encourages the City and County of San Francisco to recognize that an epidemic is in progress and that it is necessary to expedite personnel classification, testing, and requisition processing requirements that contribute to delays of more than two months in filling critical positions. CCSF should also expedite



requirements that all computer equipment (even equipment which is leased or purchased with grant funds) be part of a plan developed long before needs raised by the epidemic could possibly have been anticipated.

9. The performance of DPH-affiliated AIDS services should be assessed on a regular basis.

APPENDIX B  
ORGANIZATIONS AND INDIVIDUALS INVITED TO PARTICIPATE  
IN THE REVIEW OF THIS REPORT

SAN FRANCISCO HEALTH COMMISSION

Philip Randolph Lee, M.D., President  
Naomi T. Gray, Vice President  
John Blumlein, Commissioner  
James M. Foster, Commissioner  
Richard Sanchez, M.D., Commissioner  
Y. Clement Shek, D.D.S., Commissioner  
Rosabelle Tobriner, Commissioner

Sandy Ouye Mori, Secretary

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH  
DIRECTOR'S DEPARTMENTAL AIDS ADVISORY COMMITTEE  
David Werdegan, M.D., M.P.H., DIRECTOR

AIDS Office  
Bureau of Communicable Disease Control  
Bureau of Family Health  
Community Mental Health Services  
Community Public Health Services  
Community Substance Abuse Services  
Director's Office  
Forensic Services  
Medically Indigent Adult Program  
Microbiology Laboratory  
Office of Planning and Program Support  
Sexually Transmitted Diseases Division

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH  
COMMUNITY ADVISORY COMMITTEE

Organizational Affiliation

Asian American Residential Recovery Services  
Asian Mental Health Task Force  
Bay Area Addiction Research and Treatment  
Bay Area Physicians for Human Rights  
Black Coalition on AIDS  
California Hemophilia Association  
California Nurses Association  
CASA  
Department of Social Services  
Eighteenth Street Services  
Gay American Indians  
Gay Men's AIDS Network  
Golden Gate Business Association  
Instituto Familiar de la Raza, Latino AIDS Project  
Kaiser Permanente Hospital  
Latino Coalition for AIDS/SIDA, Educ. and Action  
Lesbian and Gay Substance Abuse Planning Group  
Operation Concern  
People with AIDS  
San Francisco AIDS Foundation  
San Francisco Human Rights Commission  
San Francisco Medical Society  
San Francisco Planned Parenthood  
SFDPH, AIDS Office  
SFDPH, City Clinic  
SFDPH, Community Public Health Services  
SFDPH, Medically Indigent Adult Program  
SFDPH, SFGH AIDS Activities Division  
SFDPH, SFGH Outpatient and Community Services  
SFDPH, SFGH Ward 93  
SFDPH Community Substance Abuse Services  
SFDPH Forensic Services  
Shanti Project  
Southeast Health Center  
Third World AIDS Advisory Committee  
UCSF Adult Human Immunodeficiency Clinic  
UCSF AIDS Health Project  
Veterans Administration Medical Center  
Visiting Nurses and Hospice of San Francisco  
Women's AIDS Network



SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH  
MINORITY AIDS ADVISORY COMMITTEE

Organizational Affiliation

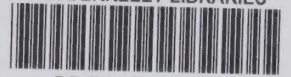
Asian American Residential Recovery Services  
Bayview Hunter's Point Foundation  
Black Coalition on AIDS  
CASA  
Gay American Indians  
Horizons, Limited  
Instituto Familiar de la Raza, Latino AIDS Project  
KWIK-FAM  
Latino Coalition on AIDS/SIDA Educ. and Action  
Multicultural Prevention Resource Center  
Native American Health Center  
San Francisco AIDS Foundation  
San Francisco Human Rights Commission  
SFDPH, AIDS Office  
SFDPH, Health Center #1  
Shanti Project  
Southeast Health Center  
UCSF AIDS Health Project  
Veterans Administration Medical Center  
Westside Community Mental Health Center

OTHER INDIVIDUALS INVITED TO REVIEW THIS REPORT

Jeffery Moulton, Ph.D.



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